

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01671

01664

|   |  |   |        |  |  |   |  |  |      |                  |  |
|---|--|---|--------|--|--|---|--|--|------|------------------|--|
| 1. DECEASED-NAME<br>(Type or print)   |  | First   | Middle | Last   | 2a. DATE OF DEATH  |   | 2b. HOUR   |  |      |                  |  |
| Dora  |  |   |        | BEARMAN  | JANUARY 11 1969  |   | 5 <sup>45</sup> AM   |  |      |                  |  |
| 3. SEX  |  | 4. RACE   |        | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR  |      | IF UNDER 24 HRS. |  |
| FEMALE  |  | White   |        | March 25, 1890   |  | 78 YRS.   |  | MONTHS   |      | DAYS             |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |  |      |                  |  |
| Baltimore Md  |  | USA   |        |  |  | Wicomico  |  |  |      |                  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)    |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |      |                  |  |
| Salisbury   |  | Peninsula General Hospital  |        | Housewife  |  | at Home   |  |  |      |                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY   |        | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET AND NUMBER                                       |      |                  |  |
| MARYLAND  |  | WICOMICO  |        | SALISBURY  |  |   |  | AVALON PARK  |      |                  |  |
| 14. FATHER'S NAME   |  | First   | Middle | Last   | 15. MOTHER'S MAIDEN NAME   |   | First  | Middle   | Last |                  |  |
| ISADORE SAMLER  |  |   |        |  | ELIZABETH  |   |  |  | ?    |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.  |        | 17. INFORMANT  |  | Address   |  |  |      |                  |  |
| NO  |  |   |        | MRS. MYRA GOLDFEIN   |  | AVALON PK. SALISBURY, MD.   |  |  |      |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |        |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 wks</u> |      |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)  |  |   |        |  |  |   |  |  |      |                  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |        |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |      |                  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |        |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |   |  |  |      |                  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |        |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                         |   |  |  |      |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 27, 1968</u> to <u>Jan 11, 1969</u> , that (I) (we) last saw the deceased alive on <u>Jan 11, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |        |  |  |   |  |  |      |                  |  |
| 22b. SIGNATURE<br><u>Robert C. Koberstein M.D.</u> DEGREE   |  |   |        |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>Jan 11, 1969</u>                      |      |                  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>Robert C. Koberstein M.D.</u>  |  |   |        |  |  | 22e. ADDRESS<br><u>Peninsula Gen. Hosp. - Salisbury, Md.</u>  |  |  |      |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE   |        | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |      |                  |  |
| BURIAL  |  | 1-13-69   |        | BALTIMORE HEBREW   |  | BALTIMORE, MARYLAND   |  |  |      |                  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>  |  |   |        |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br><u>JAN 15 1969</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>             |      |                  |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01672

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01665

|   |         |  |                                 |   |   |  |          |
|---|---------|--|---------------------------------|---|---|--|----------|
| 1. DECEASED-NAME<br>(Type or Print)   |         | First  | Middle                          | Lost  | 20. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year |  | 2b. HOUR |
| CLARA   |         | VIRGINIA   | BEDSWORTH                       |   | 1-30-69 19  |  | 2:25 P   |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (In years lost birthday) | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN.  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year   | 2d. HOUR |
| F   | W       | 9-4-1876   | 92 YRS.                         |   |   | 1 30 69  | 2:25 P   |
| 70. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                          |   | 9. COUNTY OF DEATH   |          |
| Maryland  |         | U.S.A.   |                                 |   |   | Wicomico Md.   |          |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                 | 120. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |          |
| Salisbury   |         | Peninsula General  |                                 | Housewife   |   | Own Home   |          |
| 130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         | 13b. COUNTY  |                                 | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |          |
| Md.   |         | Worcester  |                                 | Newark  |   |  |          |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME   |                                 | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |          |
| John  |         | Horseman   |                                 | 212 18-6231   |   | Mrs. Dorothy B. Taylor, Newark, Md.  |          |
| 160. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         | (If yes give war or dates of service)  |                                 | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |          |
| NO  |         |  |                                 | 485X  |   | days   |          |
|   |         |  |                                 | (b) DUE TO, OR AS A CONSEQUENCE OF  |   |  |          |
|   |         |  |                                 | (c) DUE TO, OR AS A CONSEQUENCE OF  |   |  |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |  |                                 |   |   |  |          |
| Intertrochanteric fracture of left hip.   |         |  |                                 |   |   |  |          |
| 190. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |                                 | 20. AUTOPSY?  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |          |
| 1-23-69   |         | Fracture of left hip   |                                 |   |   |  |          |
| 210. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>   |         | 21b. TIME OF INJURY Month, Day, Year   |                                 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |          |
| 4:30 P.M.   |         | 1-22-69  |                                 | Fell at own home.   |   |  |          |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                                 | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |          |
|   |         | own home   |                                 | Newark, Worcester, Md.  |   |  |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |                                 |   |   |  |          |
| ACTUAL SIGNATURE  |         | M.D.   |                                 | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   | 22b. DATE SIGNED   |          |
| Earl L. Royer, M.D.   |         |  |                                 | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   | 1-31-69  |          |
| EXAMINER'S NAME (Type)  |         | ADDRESS  |                                 | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |   |  |          |
| 409 Camden Ave.   |         | Salisbury, Md.   |                                 | ADDRESS (Street, city, town, or county)   |   |  |          |
| 230. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |                                 | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)  |          |
| Burial  |         | 2-2-69   |                                 | Trinity Garden of Memories  |   | Newark Md.   |          |
| 24. FUNERAL DIRECTOR  |         |  |                                 | 250. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |          |
| Dennis Funeral Home, Snow Hill, Md.   |         |  |                                 | DATE FEB 4 1969   |   | Charles Judge  |          |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FEB 4 1958

DEATH CERTIFICATE





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |                                   |  |  |
|--|--|--|--|---|--|---|--|-----------------------------------|--|--|
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |                                   |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |   | 2a. DATE OF DEATH  |   |  | 2b. HOUR                          |  |  |
| First Middle Last<br><b>CHARLES GILBERT BLADES</b>   |  |  |  |   | Month Day Year<br><b>January 28, 1969</b>  |   |  | 4:40A M                           |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR                   |  |  |
| Male   |  | White  |  | Jan. 20, 1896   |  | 73 YRS.   |  | MONTHS DAYS HOURS MIN             |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                                   |  |  |
| Maryland   |  | U.S.   |  |   |  | WICOMICO Md.  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| Salisbury  |  |  | Deer's Head State Hospital   |   |  | Ret. Salesman   |  |                                   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS?   |   | 13e. STREET AND NUMBER   |                                   |  |  |
| Maryland   |  |  | Dorchester   |   | Cambridge YES <input type="checkbox"/> NO <input type="checkbox"/>                   |   | 902 Locust Street  |                                   |  |  |
| 14. FATHER'S NAME First Middle Last  |  |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last   |   |  |                                   |  |  |
| Charles Blades   |  |  |  |   | Minnie Cannon  |   |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, No, or unknown)  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |   |  |                                   |  |  |
| YES  |  |  | W.W.1  |   | 902 Locust St.,<br>Mrs. Pearla H. Blades, Cambridge, Md.                             |   |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease,</b><br><b>4124</b> DUE TO, OR AS A CONSEQUENCE OF <b>decompensated</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Parkinson's disease</b>  |  |  |  |   |  |   |  |                                   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |   |  |                                   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |                                   |  |  |
| 22a. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>August 20, 1968</b> , to <b>January 28, 1969</b> , that <b>(H)</b> (we) last saw the deceased alive on <b>January 28, 1969</b> , and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above <b>(X)</b> (we) (did) (did not) view the body after death.                              |  |  |  |   |  |   |  |                                   |  |  |
| 22b. SIGNATURE<br><b>L. V. Maldve, M. D.</b>   |  |  |  |   | 22c. DATE SIGNED<br><b>1/28/69</b>   |   | 22d. PHYSICIAN'S NAME (Type)<br><b>L. V. Maldve, M. D.</b>           |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY                                   |                                   | 23d. LOCATION (City or Town) (County) (State)                |  |
| Burial   |  |  |  |   | Jan. 30, 1969  |   | East New Market Cemetery   |                                   | East New Market, Md.   |  |
| 24. FUNERAL DIRECTOR   |  |  |  |   | ADDRESS  |   | 25a. REC'D BY REGISTRAR<br>DATE                                      |                                   | 25b. REMARKS (If any)  |  |
| <b>Leurith R. Thomas</b>   |  |  |  |   | Cambridge, Md.   |   | FEB 3 1969   |                                   |  |  |

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EXHIBIT OF CASE

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CHURCH STREET, NEW YORK, N.Y. 1001

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retain any carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |   |   |   |   |  |  |
|---|--|---|---|---|---|---|---|---|--|--|
| 01674 CERTIFICATE OF DEATH 01667  |  |   |   |   |   |   |   |   |  |  |
| 1. DECEASED-NAME<br>(Type or print) <i>Priscilla Mary Briddell</i>  |  |   |   |   | 2a. DATE OF DEATH<br>Month <i>21</i> Day <i>69</i> Year   |   |   | 2b. HOUR<br><i>12:45</i> P  |  |  |
| 3. SEX<br><i>female</i>   |  | 4. RACE<br><i>white</i>   |   | 5. DATE OF BIRTH<br><i>July 25, 1880</i>  |   |   | 6. AGE (In years<br>last birthday) <i>88</i> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <i>Md.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>                                     |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><i>Wicomico</i> Md.   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Salisbury</i>   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <i>Wicomico Nursing Hosp<br/>Booth St, Salisbury, Md.</i> |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life even if retired.)<br><i>housewife</i> |   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY                             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <i>Md.</i>   |  |   | 13b. COUNTY <i>Somerset</i>   |   | 13c. CITY OR TOWN <i>Princess Anne</i>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><i>Beckford Ave.</i>                   |  |
| 14. FATHER'S NAME<br>First <i>Rufus</i> Middle <i>Powell</i> Last <i>Carey</i>  |  |   | 15. MOTHER'S MAIDEN NAME<br>First <i>Mary</i> Middle <i>Carey</i> Last <i>Carey</i>   |   |   |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)   |  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br>Address<br><i>Mrs. Norris Hancock, Princess Anne, Md.</i>  |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i><br><i>2509</i> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes mellitus</i> |  |   |   |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>1 m5.</i><br><i>15 yr</i><br><i>"</i> |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>               |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1-12, 1969</i> , to <i>1-21, 1969</i> , that (I) (we) lost<br>saw the deceased alive on <i>1-20, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |   |   |   |   |  |  |
| 22b. SIGNATURE<br><i>James L. Henman Jr.</i>  |  |   |   |   | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><i>1-21-69</i>  |   |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)   |  |   |   |   | 22e. ADDRESS  |   |   |   |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><i>Burial</i>   |  | 23b. DATE<br><i>1/23/69</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>St. Andrew's</i>   |   |   | 23d. LOCATION (City or Town) (County) (State)<br><i>Princess Anne, Somerset Md</i>              |   |  |  |
| 24. FUNERAL DIRECTOR<br><i>James L. Henman Jr.</i>  |  |   |   |   | ADDRESS<br><i>Princess Anne, Md.</i>  |   | 25a. REC'D BY REGISTRAR<br><i>DAVID A. JONES</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>David A. Jones</i>              |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |                          |   |  |  |  |   |
|---|--|--|--------------------------|---|--|--|--|---|
| 01675   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |                          |   |  | 01668  |  |   |
| CERTIFICATE OF DEATH  |  |  |                          |   |  |  |  |   |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First                    | Middle  | Lost   | 2a. DATE OF DEATH<br>Month Day Year  |  | 2b. HOUR  |
| Albert  |  |  | E.                       | Brown   |  | January 5, 1969  |  | 11:50 AM  |
| 3. SEX  |  | 4. RACE  |                          | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                      |
| Male  |  | White  |                          | MAR-15-1886   |  | 82 YRS.  |  |   |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  | Md.   |
| Maryland  |  | U. S. A.   |                          |   |  | WICOMICO   |  |   |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |
| Salisbury   |  | Deer's Head State Hospital   |                          | Retired   |  | SAIL MAKER   |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER  |
| Maryland  |  | Somerset   |                          | Wenona  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  | --  |
| 14. FATHER'S NAME   |  |  | First                    | Middle  | Lost   | 15. MOTHER'S MAIDEN NAME First Middle Lost   |  |   |
| HENRY   |  |  |                          | BROWN   |  | MARGARET WINDSOR   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO. |   | 17. INFORMANT  |  | Address  |   |
| No  |  |  | UNKNOWN                  |   | MRS. MARGARETE EICK  |  | PHILA - PA.  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchopneumonia and heart failure</u><br><u>485X</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |                          |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>5 days</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Arteriosclerotic heart disease; old CVA with left hemiparesis</u>   |  |  |                          |   |  |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |
|   |  |  |                          |   |  |  |  |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |
|   |  |  |                          |   |  |  |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |
|   |  |  |                          |   |  |  |  |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 22, 1967</u> , to <u>January 5, 1969</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>January 5, 1969</u> , and that in <input checked="" type="checkbox"/> (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <del>XXXXX</del> view the body after death. |  |  |                          |   |  |  |  |   |
| 22b. SIGNATURE <u>C. H. Winnacott</u>   |  |  |                          |   |  | 22c. DATE SIGNED<br>1/6/69   |  |   |
| 22d. PHYSICIAN'S NAME (Type) C. H. Winnacott, M. D.   |  |  |                          |   |  | 22e. ADDRESS<br>Deer's Head State Hospital, Salisbury,                                       |  | Maryland  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |   |
| Burial  |  | 1/9/69   |                          | ST. JOHN'S CEMETERY   |  | Deer's Head State Hospital   |  |   |
| 24. FUNERAL DIRECTOR  |  |  |                          | ADDRESS   |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                    |
| Leroy Webster Primmers  |  |  |                          | Md.   |  | JAN 14 1969  |  | Charles Judge   |

1968

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1968

January 2, 1968

MEMORANDUM

U.S. Navy State Hospital

San Francisco, California

Subject: [Illegible]

Reference is made to [Illegible]

Enclosed for [Illegible]

Very truly yours,

U. S. Navy State Hospital, San Francisco, California

1968



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

|  |  |                              |  |  |                                    |   |  |  |                                   |   |                            |  |
|--|--|------------------------------|--|--|------------------------------------|---|--|--|-----------------------------------|---|----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                              |  |  |                                    |   |  |  |                                   |   |                            |  |
| Items 1, 5 taken from birth certificate 2/3/69 11  |  |                              |  |  |                                    |   |  |  |                                   |   |                            |  |
| CERTIFICATE OF DEATH   |  |                              |  |  |                                    |   |  |  |                                   |   |                            |  |
| 01669  |  |                              |  |  |                                    |   |  |  |                                   |   |                            |  |
| 1. DECEASED-NAME (Type or print) First Middle Last   |  |                              |  |  | 2a. DATE OF DEATH+ Month Day Year  |   |  |  |                                   | 2b. HOUR  |                            |  |
| Baby Fredia Louise Brown   |  |                              |  |  | January 12 69                      |   |  |  |                                   | 3 55 A M  |                            |  |
| 3. SEX   |  | RACE                         |  | 5. DATE OF BIRTH   |                                    |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR MONTHS DAYS       |   | IF UNDER 24 HRS. HOURS MIN |  |
| Female   |  | Col                          |  | 11/11/12/11/16/4   |                                    |   | 11 1/2 YRS.  |  |                                   |   | 1 40                       |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH  |  |  |                                   |   |                            |  |
| W.D.C.   |  | U.S.A.                       |  |  |                                    | Wicomico Md.  |  |  |                                   |   |                            |  |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |                            |  |
| Salisbury  |  |                              | Peninsula General Hospital   |  |                                    |   |  |  |                                   |   |                            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN                  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER            |   |                            |  |
| S.D.C.   |  |                              | Coles  |  | Sales                              |   |  |  | Lake St City                      |   |                            |  |
| 14. FATHER'S NAME First Middle Last  |  |                              | 15. MOTHER'S MARRIED NAME First Middle Last                                  |  |                                    |   |  |  |                                   |   |                            |  |
| Shirley Brown  |  |                              | Helen Hamilton   |  |                                    |   |  |  |                                   |   |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |                              | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address              |   |  |  |                                   |   |                            |  |
| No   |  |                              | 1234   |  | Shirley Brown                      |   |  |  |                                   |   |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |                              |  |  |                                    |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |                            |  |
| 7769 IMMEDIATE CAUSE (a) atelectasis   |  |                              |  |  |                                    |   |  |  |                                   |   |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |                              |  |  |                                    |   |  |  |                                   |   |                            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity   |  |                              |  |  |                                    |   |  |  |                                   |   |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |                              |  |  |                                    |   |  |  |                                   |   |                            |  |
| (c)  |  |                              |  |  |                                    |   |  |  |                                   |   |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                              |  |  |                                    |   |  |  |                                   |   |                            |  |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                    | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |   |                            |  |
|  |  |                              |  |  |                                    |   |  |  |                                   |   |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |  |                                   |   |                            |  |
|  |  |                              |  |  |                                    |   |  |  |                                   |   |                            |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |  |  |                                   |   |                            |  |
|  |  |                              |  |  |                                    |   |  |  |                                   |   |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |  |                                    |   |  |  |                                   |   |                            |  |
| 22b. SIGNATURE   |  |                              |  |  |                                    |   |  |  |                                   | 22c. DATE SIGNED                                |                            |  |
| William C. Morgan DEGREE   |  |                              |  |  |                                    |   |  |  |                                   |   |                            |  |
| 22d. PHYSICIAN'S NAME (Type) William C. Morgan   |  |                              |  |  |                                    |   |  |  |                                   | 22e. ADDRESS MEDICAL CENTER SALISBURY, MARYLAND |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |   | 23d. LOCATION (City or Town) (County) (State)  |  |                                   |   |                            |  |
| Burial   |  |                              | Jan 24-69  |  | Eden Com                           |   | Eden Md Somerset Md  |  |                                   |   |                            |  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |                              |  |  |                                    | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |                                   |   |                            |  |
| Barbara West   |  |                              |  |  |                                    | FEB 3 1969  |  | Charles Judge  |                                   |   |                            |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 01670   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                |  |   |  | 01670  |  |
| Item 6 Film G408 1/21/69 kk   |  |  |  |   |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>LOUISE EWELL BROWN  |  |  |  | 2a. DATE OF DEATH Month Day Year<br>JANUARY 15 1969   |  | 2b. HOUR<br>6:45 P.M.  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>July 17, 1888   |  | 6. AGE (In years last birthday)<br>81 1/2 YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Md   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Wicomico Md.   |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Peninsula General Hospital |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>None  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md   |  | 13b. COUNTY<br>Delmar  |  | 13c. CITY OR TOWN<br>Delmar   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br>9 E. Pine St  |  |  |  |   |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>Oscar Ewell  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Marie Nord  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown)<br>No  |  | 16b. SOCIAL SECURITY NO<br>215-48-1672   |  | 17. INFORMANT Address<br>Oscar E. Brown Delmar, Del   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>4123 IMMEDIATE CAUSE (a) <u>Arterio sclerotic Heart</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____ |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>several                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-10, 1969, to 1-15, 1969, that (I) (we) last saw the deceased alive on 1-15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>William D. Carter   |  |  |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                              |  | 22c. DATE SIGNED<br>1-15-69  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  | 22e. ADDRESS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br>1/14/69   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Stephens  |  | 23d. LOCATION (City or Town) (County) (State)<br>Delmar Sussex Del                           |  |
| 24. FUNERAL DIRECTOR<br>William D. Carter   |  |  |  | ADDRESS<br>Delmar, Del.   |  | 25a. REC'D BY REGISTRAR<br>JAN 17 1969   |  |
|   |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |  |

07911

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY MEDICAL DEPARTMENT

OFFICE OF THE DIRECTOR

WASHINGTON, D. C.

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

MEDICAL CERTIFICATE

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January 17, 1912

TO  
FROM  
SUBJECT  
REMARKS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 01679   |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |   |  | 01672   |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>Florence Evelyn CHEEZUM  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br>JANUARY 19 1969 |   |  | 2b. HOUR<br>1 18 PM   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>March 14, 1892  |  | 6. AGE (In years last birthday)<br>76 YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Wicomico Md.  |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Peninsula Gen'l                    |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housework  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  | 13b. COUNTY<br>Caroline  |  | 13c. CITY OR TOWN<br>Preston  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME First Middle Last<br>I. Jerome Chambers   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Annie Rebecca Todd   |  | 13e. STREET AND NUMBER<br>Poplar Neck Road  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) No  |  | 16b. SOCIAL SECURITY NO.<br>214-32-0342  |  | 17. INFORMANT Address<br>Mrs. Kenneth Lane, Preston, Maryland   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u><br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Coronary Atherosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>12 hrs  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>David J. Gibmore  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>David J. Gibmore M.D.   |  |  |  | 22e. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>1-21-1969   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Junior Order Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Preston, Caroline, Md.                         |  |
| 24. FUNERAL DIRECTOR<br>Jerome Frampton, Jr.<br>J. J. Frampton and Son, Federalsburg, Md.   |  |  |  | 25a. REGISTRY STRA...<br>JAN 21 1969  |  | 25b. REGISTRY STRA...<br>JAN 21 1969  |  |

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CHAMBER OF COMMERCE

1917

*[Faint, mostly illegible text and markings, possibly a ledger or form, with some handwritten notes and stamps.]*

CHAMBER OF COMMERCE

1917

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |                      |  |   |  |  |  |   |   |                   |  |
|--|----------------------|--|---|--|--|--|---|---|-------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                      |  |   |  |  |  |   |   |                   |  |
| 1. DECEASED-NAME<br>(Type or Print) <b>JANET L. CHRISTOPHER</b>  |                      |  | First Middle Lost   |  |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input checked="" type="checkbox"/> <b>1-17-69</b> |   | 2b. HOUR <input type="checkbox"/> M <input type="checkbox"/> AM <input type="checkbox"/> PM |                   |  |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>AA</b> | 5. DATE OF BIRTH<br><b>11-6-68</b>   | 6. AGE (In years last birthday)<br><b>2</b> YRS <b>11</b> MONTHS <b>11</b> DAYS | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD<br>Month <b>1</b> Day <b>17</b> Year <b>69</b>  |   | 2d. HOUR <b>6:25</b> AM   |                   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Wico.</b>  |                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Wicomico</b>  |   | Md  |                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>  |                      | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Peninsula General</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>None</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |   |   |                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>   |                      | 13b. COUNTY <b>Wicomico</b>  |   | 13c. CITY OR TOWN <b>Fruitland</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET AND NUMBER <b>S. Div. St. Ext.</b>  |                   |  |
| 14. FATHER'S NAME<br><b>Ronald Christopher</b>   |                      |  | First Middle Lost   |  |  | 15. MOTHER'S MAIDEN NAME<br><b>Elyse Christopher</b>   |   |   | First Middle Lost |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>   |                      |  | 16b. SOCIAL SECURITY NO.<br><b>none</b>   |  | 17. INFORMANT<br><b>Ronald Christopher</b> |  |   |   |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Interstitial pneumonitis</b><br><b>484X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                      |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>hours</b>                                |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>SUDDEN DEATH IN INFANCY.</b>   |                      |  |   |  |  |  |   |   |                   |  |
| 19a. DATE OF OPERATION   |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                               |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |                   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                      | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>19</b> P.M.   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |   |   |                   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                      | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                             |   | 21f. LOCATION Street or R.F.D. No.   |  | City or Town   |   | County State  |                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                      |  |   |  |  |  |   |   |                   |  |
| ACTUAL SIGNATURE<br><b>Earl L. Royer, M.D.</b>   |                      | EXAMINER'S NAME (Type)<br><b>409 Camden Ave., Salisbury, Md</b>  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                 |                   |  |
|  |                      |  |   | 22b. DATE SIGNED<br><b>Jan. 21, 1969</b>   |  |  |   |   |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                      | 23b. DATE<br><b>1-23-69</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>West Rest Office</b>  |  | 23d. LOCATION (City or Town)<br><b>West Rest Office</b>  |   | (County) (State)  |                   |  |
| 24. FUNERAL DIRECTOR<br><b>Booker West, Salisbury, Md.</b>   |                      |  |   | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 29 1969</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>                                       |                   |  |

STATE OF  
NEW YORK

IN SENATE  
JANUARY 1, 1932

REPORT OF THE  
COMMISSIONER OF THE  
DEPARTMENT OF  
CORRECTIONS  
FOR THE YEAR  
1931

1932

REPORT OF THE  
COMMISSIONER OF THE  
DEPARTMENT OF  
CORRECTIONS  
FOR THE YEAR  
1931

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| STATE OF NEW YORK |  | IN SENATE           |  | JANUARY 1, 1932 |  |
| REPORT OF THE     |  | COMMISSIONER OF THE |  | DEPARTMENT OF   |  |
| CORRECTIONS       |  | FOR THE YEAR        |  | 1931            |  |
| 1932              |  | 1931                |  | 1930            |  |
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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form #MS-7. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01681

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01674

|   |         |  |        |   |   |  |  |
|---|---------|--|--------|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or Print)   |         | First  | Middle | Last  | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year<br>OF ESTI-<br>DEATH MATED <input type="checkbox"/> 1-14-69 <sub>19</sub> |  | 2b. HOUR <input type="checkbox"/> 3:55 <sub>P</sub>              |
| JOHN  |         | LAWRENCE   |        | COLLIER   |   |  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |        | 6. AGE (In years last birthday)   | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN.   | 2c. DATE PRONOUNCED DEAD<br>Month 1 Day 14 Year 69 <sub>19</sub> |
| Male  | White   | 11-30-17   |        | 51 YRS.   |   |  | 2d. HOUR <input type="checkbox"/> 3:55 <sub>P</sub>              |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Wicomico   |  |
| Md.   |         | U.S.A.   |        |   |   | Md.  |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)             |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Salisbury   |         | Peninsula General  |        | Waterman  |   | Deuford  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         | 13b. COUNTY  |        | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| Md.   |         | Wicomico   |        | Salisbury   |   | Riverside Drive Ext.   |  |
| 14. FATHER'S NAME   |         | First  | Middle | Last  | 15. MOTHER'S MAIDEN NAME  |  | First Middle Last  |
| MARION  |         | COLLIER  |        | MARGERY   |   | WHITE  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |         | 16b. SOCIAL SECURITY NO.   |        | 17. INFORMANT   |   | ADDRESS  |  |
| No  |         | UNKNOWN  |        | ELIZABETH WEBSTER   |   | MARYLAND WENONA  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Bullet wound of brain<br>DUE TO, OR AS A CONSEQUENCE OF<br>955X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |         |  |        |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>days             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Depression.   |         |  |        |   |   |  |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |        |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 1-6-69                            |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Shot self with pistol.   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br>own home |        | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>Riverside Dr. Ext., Salisbury, Wic., Md.  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |  |        |   |   |  |  |
| ACTUAL SIGNATURE  |         | Earl L. Royer, M.D.  |        | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   | 22b. DATE SIGNED   |  |
| EXAMINER'S NAME (Type)  |         | 409 Camden Ave., Salisbury, Md   |        | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   | Jan. 16, 1969  |  |
|   |         |  |        | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   | ADDRESS (Street, city, town, or county)  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)  |  |
| Burial  |         | 1/17/69  |        | ST. PAUL'S CEMETERY   |   | Wenona Som Md.   |  |
| 24. FUNERAL DIRECTOR  |         | Webster Funeral Home, Princess Anne, Md  |        | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |  |
|   |         |  |        | JAN 21 1969   |   | Charles Judge  |  |

100% COTTON T-SHIRT



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1-68  
30M RE-1/68

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|---|--|--|--|---|--|---|--|
| 01682   |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |   |  | 01675   |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) <b>FRED</b> First <b>CARTEZ</b> Middle <b>COOPER</b> Last   |  |  | 2a. DATE OF DEATH<br>Month <b>JAN</b> Day <b>13</b> Year <b>1969</b> |   |  | 2b. HOUR <b>15</b> M  |  |
| 3. SEX <b>M</b>   |  | 4. RACE <b>W</b>   |  | 5. DATE OF BIRTH<br><b>Nov 13/1902</b>  |  | 6. AGE (In years last birthday) <b>66</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>QUANTICO</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>WICOMICO</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>WETIPPUINN</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>—</b>                              |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>FARMER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>  |  | 13b. COUNTY <b>WICOMICO</b>  |  | 13c. CITY OR TOWN <b>WETIPPUINN</b>   |  | 13d. INDEPENDENT CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |  |
| 13e. STREET AND NUMBER <b>—</b>   |  | 14. FATHER'S NAME First <b>CORTEZ</b> Middle <b>O.</b> Last <b>COOPER</b>  |  | 15. MOTHER'S MAIDEN NAME First <b>MARGARET</b> Middle <b>HOPKINS</b> Last <b>COOPER</b>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service) |  |
| 16b. SOCIAL SECURITY NO. <b>219-07-625</b>  |  | 17. INFORMANT <b>SON</b>   |  | 17. ADDRESS <b>S. PARK DR, SALISBURY</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4109</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE CORONARY OCCLUSION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>10YRS</b> |  |  |  |   |  | 18. CAUSE OF DEATH (continued)  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 59</b> , 19 <b>68</b> , to <b>JAN. 69</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>Nov 19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) we (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>Rufus S. Gardner Jr</b>   |  | DEGREE <b>—</b>  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED <b>1/13/69</b>   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>RUFUS S. GARDNER JR</b>   |  | 22e. ADDRESS <b>QUANTICO ROAD, SALISBURY MD</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |  | 23b. DATE <b>1/16/69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Mem. Park</b>  |  | 23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Md.</b>   |  |
| 24. FUNERAL DIRECTOR <b>Charles B. Buzze</b>  |  | ADDRESS <b>Mt. Pleasant, Md.</b>   |  | 25a. REC'D BY REGISTRAR <b>JAN 16 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles B. Buzze</b>  |  |

George W. Brown

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |
| 01683   |  |  |  |   |  |   |  |  |  |
| 01676   |  |  |  |   |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |   |  | 2a. DATE OF DEATH<br>Month Day Year   |  |  | 2b. HOUR<br>M  |
| FRANK   |  |  | Cornish  |   |  | JANUARY 5, 1969   |  |  | 5:28   |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  |
| MALE  |  | Negro  |  | 8-16-1897   |  | 71 YRS.   |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |  | Md.  |
| Md.   |  | U.S.A.   |  |   |  | Wicomico  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                      |
| SALISBURY   |  |  | PENINSULA General Hosp   |   |  | Laborer   |  |  | Factory  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| MARYLAND  |  |  | Worcester  |   |  | Pocomoke  |  | Route 2 Bx. 31   |  |
| 14. FATHER'S NAME<br>First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last                                |   |  |   |  |  |  |
| Leri Cornish  |  |  | Hallie Van Leah  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no or unknown  |  |  | 16b. SOCIAL SECURITY NO.   |   |  | 17. INFORMANT<br>Address  |  |  |  |
| Yes   |  |  | WWI  |   |  | 215-05-8649 Virginia Cornish Rt. 2 Pocomoke, Md.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4339 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arterio sclerosis (c) Hypertension |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 week |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |  |  |
| MEDICAL CERTIFICATION   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/15, 1968, to 1/5, 1969, that (I) (we) last saw the deceased alive on 1/5, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Charles Judge   |  |  |  |   |  | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1/8/69   |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |   |  | 22e. ADDRESS  |  |  |  |
|   |  |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |  |
| Burial  |  | 1-9-69   |  | Baltimore National Cem.   |  | Baltimore Md.   |  |  |  |
| 24. FUNERAL DIRECTOR<br>Samuel Savage   |  |  |  | ADDRESS<br>New Church, Va.  |  | 25a. REC'D BY REGISTRAR<br>JAN 10 1969  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |                          |   |  |  |  |                                   |   |  |
|---|--|--|--------------------------|---|--|--|--|-----------------------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |                          |   |  |  |  |                                   |   |  |
| CERTIFICATE OF DEATH  |  |  |                          |   |  |  |  |                                   |   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First                    | Middle  | Last   | 2a. DATE OF DEATH<br>Month Day Year  |  |                                   | 2b. HOUR  |  |
| Julia   |  |  | A                        |   | CORNISH  | JANUARY 29 1969  |  |                                   | 5:45 M  |  |
| 3. SEX  |  | 4. RACE  |                          | 5. DATE OF BIRTH  |  | 6. AGE (in years last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS    |   |  |
| FEMALE  |  | C  |                          | 3/12/1897   |  | 71 YRS.  |  |                                   |   |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  | Md.                               |   |  |
| Maryland  |  | U.S.A.   |                          |   |  | Wicomico   |  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| Salisbury   |  | Peninsula General Hospital   |                          |   |  | Domestic   |  | None                              |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER            |   |  |
| Maryland  |  | Wicomico   |                          | Salisbury   |  |  |  | Hearne Lane                       |   |  |
| 14. FATHER'S NAME   |  |  | First                    | Middle  | Last   | 15. MOTHER'S MAIDEN NAME   |  |                                   | First Middle Last                                     |  |
| William   |  |  |                          |   | Full   | Sarah  |  |                                   | ?   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO. |   | 17. INFORMANT  |  |  |                                   | Address   |  |
| No  |  |  |                          |   | Gorgia Lawrence Hebron Md.   |  |  |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Heart Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF, (c) <u>Quick death</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |                          |   |  |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hr. |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |                          |   |  |  |  |                                   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                          |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |                                   |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          |   | 21f. LOCATION: Street or R.F.D. No. City or Town County State  |  |  |                                   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 68 to 19 69, that (I) (we) lost saw the deceased alive on 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.  |  |  |                          |   |  |  |  |                                   |   |  |
| 22b. SIGNATURE  |  |  |                          |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED   |                                   |   |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |                          |   | 22e. ADDRESS   |  |  |                                   |   |  |
| Harnell, M.D.   |  |  |                          |   | 652 W. Main Salisbury, Md.   |  |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |                                   |   |  |
| Burial  |  | 2/2/1969   |                          | Green Acres   |  | Salisbury Wicomico Md.   |  |                                   |   |  |
| 24. FUNERAL DIRECTOR  |  |  |                          |   | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |                                   |   |  |
| Clifton F. Stewart  |  |  |                          |   | P.E.B. 7 1969  |  | James J. Jones   |                                   |   |  |



1878

CERTIFICATE OF DEATH

1878

3/12/1878

William  
of all  
bank

Wm. H. Street



CERTIFICATE OF DEATH

01685

01678

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Wicomico</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <u>MARYLAND</u> b. COUNTY <u>W. COMICO</u>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>  |  | c. LENGTH OF STAY IN 1b <u>3 yrs.</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>  |  | d. STREET ADDRESS <u>Rt # 5</u>  |   |
| 3. NAME OF DECEASED<br>(Type or print) First <u>LEAR</u> Middle <u>Elizabeth</u> Last <u>COULBOURN</u>   |  | 4. DATE OF DEATH Month <u>JAN</u> Day <u>9</u> Year <u>1969</u>  |   |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>Negro</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 16, 1894</u>                           |
| 9. AGE (In years lost birthday) <u>74</u> yrs.   |  | IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>MARDELA SPRINGS U.S.A.</u>  |   |
| 13. FATHER'S NAME <u>John Wesley Horsey</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Epluribus Morris</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>2.19-05-3581</u>  |  | 17. INFORMANT Address <u>Bertha Hull SALISBURY, Md. Rt # 5</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br>4109 DUE TO (b) <u>Coronary artery disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>unknown</u> |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>16 min.</u>                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                            |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5/1</u> , 19 <u>58</u> , to <u>death</u> , 19 <u>—</u> , that (I) (we) last saw the deceased alive on <u>Jan 7</u> , 19 <u>69</u> , and that death occurred at <u>4:10 P.M.</u> , from causes and on the date stated above.                                   |  |  |   |
| 22a. SIGNATURE <u>Ernest Larmore</u>   |  | 22b. DATE SIGNED <u>1/10/69</u>  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>ERNEST LARMORE</u>   |  | 22d. ADDRESS <u>DELMAR DEL.</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  | 23b. DATE THEREOF <u>1-13-69</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>  | 23d. LOCATION (City or Town) (County) (State) <u>MARDELA Sp</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>JOLLEY MEMORIAL Chapel JERSEY Rd. SALISBURY Md.</u>  |  | 25a. REC'D BY REGISTRAR DATE <u>14 1969</u>  |   |
|  |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Young</u>  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

THE OFFICE OF THE SECRETARY OF THE ARMY

1914

OFFICE OF THE SECRETARY OF THE ARMY

1914

TO THE SECRETARY OF THE ARMY  
FROM THE SECRETARY OF THE ARMY  
SUBJECT: [Illegible]  
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or official communication.]

RECEIVED  
[Illegible stamp]

1914

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |  |  |   |  |  |                            |  |   | 01679  |                        |          |
|---|---------|--|--|---|--|--|----------------------------|--|---|--|------------------------|----------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |  |  |   |  |  |                            |  |   |  |                        |          |
| 1. DECEASED-NAME<br>(Type or Print)   |         |  | First  |   | Middle   |  | Last                       |  | 2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year |  |                        | 2b. HOUR |
| ISAIAH  |         |  | FRANCIS  |   | DAISEY   |  |                            |  |   | 1-27-69                                      |                        | 9:50 AM  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (in years last birthday)                     | IF UNDER 1 YEAR MONTHS DAYS                                  |  | IF UNDER 24 HRS. HOURS MIN |  | 2c. DATE PRONOUNCED DEAD Month Day Year   |  | 2d. HOUR               |          |
| Male  | White   | 2 April 1890   |  | 78 YRS.   |  |  |                            |  | 1 Day 27 Year 1969  |  | 9:50 AM                |          |
| 7a. BIRTHPLACE (State or foreign country)   |         |  | 7b. CITIZEN OF WHAT COUNTRY?   |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            |  | 9. COUNTY OF DEATH  |  |                        |          |
| Delaware  |         |  | USA.   |   |  |  |                            |  | Wicomico  |  |                        |          |
| 10. CITY OR TOWN OF DEATH   |         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working-life, even if retired.)  |                            |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                        |          |
| Salisbury   |         |  | Peninsula General  |   |  | Retired Farmer   |                            |  | Same  |  |                        |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |  | 13b. COUNTY  |   |  | 13c. CITY OR TOWN  |                            |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  | 13e. STREET AND NUMBER |          |
| Del.  |         |  | Sussex   |   |  | Frankford  |                            |  |   |  | Route 1                |          |
| 14. FATHER'S NAME First Middle Last   |         |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last          |  |  |                            |  |   |  |                        |          |
| Charles W. Daisey   |         |  |  | Marie Evans   |  |  |                            |  |   |  |                        |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         |  |  | 16b. SOCIAL SECURITY NO.                            |  |  |                            | 17. INFORMANT ADDRESS  |   |  |                        |          |
| No  |         |  |  | 222-24-1421-A                                       |  |  |                            | Thelma Schmidt Salisbury, Maryland   |   |  |                        |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |  |   |  |  |                            |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                        |          |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion   |         |  |  |   |  |  |                            |  |   | hours  |                        |          |
| 4109 DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |  |                            |  |   |  |                        |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardio-vascular disease   |         |  |  |   |  |  |                            |  |   | years  |                        |          |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |         |  |  |   |  |  |                            |  |   |  |                        |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |  |  |   |  |  |                            |  |   |  |                        |          |
| 19a. DATE OF OPERATION  |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |                            | 2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |                        |          |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |  |  | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                            |  |   |  |                        |          |
|   |         |  |  | 19  |  |  |                            |  |   |  |                        |          |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State |  |                            |  |   |  |                        |          |
|   |         |  |  |   |  |  |                            |  |   |  |                        |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |  |   |  |  |                            |  |   |  |                        |          |
| ACTUAL SIGNATURE  |         |  |  | M.D.  |  |  |                            | 22b. DATE SIGNED   |   |  |                        |          |
| Earl L. Royer, M.D.   |         |  |  |   |  |  |                            | Jan. 27, 1969  |   |  |                        |          |
| EXAMINER'S NAME (Type)  |         |  |  | ADDRESS (Street, city, town, or county)             |  |  |                            |  |   |  |                        |          |
| 4109 Camden Ave, Salisbury, Md.   |         |  |  |   |  |  |                            |  |   |  |                        |          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                  |  |  |                            | 23d. LOCATION (City or Town) (County) (State)                                    |   |  |                        |          |
| Burial  |         | 30 January 69  |  | Millsboro Cemetery Inc.                             |  |  |                            | Millsboro - Sussex - Dela.   |   |  |                        |          |
| 24. FUNERAL DIRECTOR ADDRESS  |         |  |  | 25a. REC'D BY REGISTRAR DATE                        |  | 25b. REGISTRAR'S SIGNATURE   |                            |  |   |  |                        |          |
| James Funeral Home, Millsboro, Del.   |         |  |  | JAN 30 1969   |  | [Signature]  |                            |  |   |  |                        |          |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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23  
2

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 01687  |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |   |  | 01680   |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>LOLA MAE Deshields   |  |  |  |   |  | 2a. DATE OF DEATH Month Day Year<br>JANUARY 20 1969   |  | 2b. HOUR<br>5P. M                            |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>NEGRO   |  | 5. DATE OF BIRTH<br>MARCH 2, 1900   |  | 6. AGE (In years last birthday)<br>68 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN     |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Snow Hill   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>WICOMICO Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>SALISBURY   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Peninsula                          |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housekeeper  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>None   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MARYLAND  |  | 13b. COUNTY<br>Worcester   |  | 13c. CITY OR TOWN<br>SNOW HILL  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>R.F.D.             |  |
| 14. FATHER'S NAME First Middle Last<br>Amuel Duncan  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Catherine Hudson   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br>Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>Harry Deshields  |  | Address<br>Snow Hill, Md.   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple Pulmonary Emboli</u><br>450 X DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Diabetic Mellitus Hypertension Syndrome Shunt in interval</u>   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-11-1969</u> , to <u>1-20-1969</u> , that (I) (we) last saw the deceased alive on <u>1-11-69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>James H. Coffer  |  | DEGREE   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br>2-4-69  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  | 22e. ADDRESS<br>Medical Center Salisbury Md.  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br>1-25-69   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Friendship  |  | 23d. LOCATION (City or Town) (County) (State)<br>Whitson Wore. Md.                              |  |  |  |
| 24. FUNERAL DIRECTOR<br>Solley Funeral Home Salisbury, Md.   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 7 1969  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |  |  |

10-10-40

RECEIVED BY THE OFFICE OF THE ATTORNEY GENERAL

STATE OF CALIFORNIA

IN SENATE, JANUARY 10, 1940.

REPORT

OF THE

COMMISSIONER

OF THE LAND COMMISSION

FOR THE YEAR 1939

AND

1940

AND

RECOMMENDATIONS

FOR THE YEAR 1940

AND

RECOMMENDATIONS

FOR THE YEAR 1940



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

01688

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01681

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |                  |                                     |  |   |  |   |   |  |   |           |  |               |
|---|------------------|-------------------------------------|--|---|--|---|---|--|---|-----------|--|---------------|
| 1. DECEASED-NAME<br>(Type or Print)   |                  |                                     | First  | Middle  | Last   | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED   |   |  | <input type="checkbox"/> Month<br><input type="checkbox"/> Jan. 4                   | Day<br>19 | Year<br>69   | 2b. HOUR<br>M |
| JOHN WILLIAM DYKES  |                  |                                     |  |   |  |   |   |  |   |           |  |               |
| 3. SEX<br>Male  | 4. RACE<br>White | 5. DATE OF BIRTH<br>May 16, 1897    | 6. AGE (In years<br>last birthday)<br>71 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.  |   | 2c. DATE PRONOUNCED DEAD<br>Month Day Year                                     |   |           | 2d. HOUR<br>M  |               |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>WICOMICO  |   |  |   |           |  |               |
| 10. CITY OR TOWN OF DEATH<br>Salisbury  |                  |                                     | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Peninsula General Hospital  |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Retired Lumberman |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Lumber Co.                                  |           |  |               |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland  |                  |                                     | 13b. COUNTY<br>Wicomico  |   | 13c. CITY OR TOWN<br>Salisbury                                   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>806 S. Division Street                                    |           |  |               |
| 14. FATHER'S NAME<br>George W. Dykes  |                  |                                     | 15. MOTHER'S MAIDEN NAME<br>Mary Ann Owens   |   |  |   |   |  |   |           |  |               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No   |                  |                                     | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>214-16-4444   |   | 17. INFORMANT (Wife)<br>Mrs. Sadie E. Dykes, Salisbury, Maryland |   |   | ADDRESS 806 S. Div. St.  |   |           |  |               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>4109<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. }<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                  |                                     |  |   |  |   |   |  |   |           | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>hours |               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |                  |                                     |  |   |  |   |   |  |   |           |  |               |
| 19a. DATE OF OPERATION  |                  |                                     | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?   |   |  |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |           |  |               |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                  |                                     | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19   |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                 |   |  |   |           |  |               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |                  |                                     | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)  |   |  | 21f. LOCATION Street or R.F.D. No.  |   |  | City or Town  |           | County State   |               |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion<br>death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                  |                                     |  |   |  |   |   |  |   |           |  |               |
| ACTUAL<br>SIGNATURE<br>EXAMINER'S<br>NAME (Type)<br>Earl L. Royer, M.D.<br>409 Camden Ave., Salisbury, Md.  |                  |                                     | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ADDRESS (Street, city, town, or county) |   |  |   |   |  | 22b. DATE SIGNED<br>January 6/1969  |           |  |               |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |                  |                                     | 23b. DATE<br>Jan. 7, 1969  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Wicomico Memorial Park     |   |   | 23d. LOCATION (City or Town) (County) (State)<br>Salisbury, Wicomico, Maryland |   |           |  |               |
| 24. FUNERAL DIRECTOR<br>HOLLOWAY & COMPANY, SALISBURY, MARYLAND   |                  |                                     |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE 8 1969  |   |  | 25b. REGISTRAR'S SIGNATURE<br>J. A. N. J. J.  |           |  |               |

STATE OF TEXAS  
HEALTH DEPT.



RECEIVED BY THE STATE DEPT. OF HEALTH



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1000. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |                              |  |  |   |   |   |   |  |
|---|---------|------------------------------|--|--|---|---|---|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |                              |  |  |   |   |   |   |  |
| 1. DECEASED-NAME<br>(Type or Print)   |         |                              | First Middle Last  |  |   | 2a. DATE KNOWN OF DEATH   |   |   | 2b. HOUR                                     |
| ALICE STAPLES ECKERT  |         |                              |  |  |   | Month Day Year  |   |   | 11 45 AM                                     |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (in years last birthday)  | IF UNDER 1 YEAR  |   | IF UNDER 24 HRS.  |   | 2c. DATE PRONOUNCED DEAD  |  |
| Female  | White   | Nov. 20, 1890                | 78 YRS.  | MONTHS   | DAYS  | HOURS   | MIN   | Day 26 Year 1969  | 11 45 AM                                     |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED   |   | 9. COUNTY OF DEATH  |   |   |  |
| New York  |         | U.S.A.                       |  | WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | WICOMICO  |   | Md.   |  |
| 10. CITY OR TOWN OF DEATH   |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Salisbury   |         |                              | Peninsula Gen. Hosp.   |  |   | none  |   |   | --   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)   |         |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?  |   | 13e. STREET AND NUMBER                       |
| Maryland  |         |                              | Worcester  |  | Pocomoke  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | Clarke Avenue, Ext.                          |
| 14. FATHER'S NAME   |         |                              | 15. MOTHER'S MAIDEN NAME   |  |   |   |   |   |  |
| First Middle Last   |         |                              | First Middle Last  |  |   |   |   |   |  |
| Andrew Newkirk Eckert   |         |                              | Hannah Maria Slater  |  |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |         |                              | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |   |   |   |  |
| (Yes, no, or unknown) no  |         |                              | (If yes give war or dates of service) --                                     |  | 220-52-9062 Mrs Hester Stant, Pocomoke, Maryland                                |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).)  |         |                              |  |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:  |         |                              |  |  |   |   |   |   |  |
| IMMEDIATE CAUSE (a) <u>Uremia</u>   |         |                              |  |  |   |   |   |   | Days   |
| DUE TO, OR AS A CONSEQUENCE OF  |         |                              |  |  |   |   |   |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |         |                              |  |  |   |   |   |   | years  |
| (b) <u>Cardio vascular renal disease</u>  |         |                              |  |  |   |   |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |                              |  |  |   |   |   |   |  |
| (c) <u>ASCVD</u>  |         |                              |  |  |   |   |   |   | years  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)  |         |                              |  |  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |         |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |   | 20. AUTOPSY?  |  |
|   |         |                              |  |  |   |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>   |         |                              | 21b. TIME OF INJURY Month, Day, Year   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |   |   |  |
| CAUSE OF DEATH  |         |                              | HOUR A.M. P.M.   |  | 19  |   |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |   |   |  |
|   |         |                              |  |  |   |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                              |  |  |   |   |   |   |  |
| ACTUAL SIGNATURE  |         |                              | M.D.   |  |   | 22b. DATE SIGNED  |   |   |  |
| EXAMINER'S NAME (Type)  |         |                              | ADDRESS (Street, city, town or county)                                       |  |   | 1-25-69   |   |   |  |
| Earl L. Rayer Salisbury   |         |                              |  |  |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE                    |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)   |   |   |  |
| Burial  |         | 1-28-1969                    |  | Riverside  |   | Marlboro-Ulster-New York  |   |   |  |
| 24. FUNERAL DIRECTOR ADDRESS  |         |                              |  |  |   | 25a. REC'D BY REGISTRAR DATE  |   | 25b. REGISTRAR'S SIGNATURE  |  |
| Robert H. Watson Pocomoke, Maryland   |         |                              |  |  |   | JAN 28 1969   |   | Clarence Young  |  |

STATE  
FEDERAL

10-10-10

7

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A14  
45M - 69

|  |         |   |                  |   |  |   |   |   |      |
|--|---------|---|------------------|---|--|---|---|---|------|
| 01690  |         | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201     |                  |   |  | 01683   |   |   |      |
| 1. DECEASED-NAME<br>(Type or print)  |         | First   | Middle           | Lost  | 2a. DATE OF DEATH<br>Month Day Year  |   | 2b. HOUR<br>M   |   |      |
| DALLAS   |         | MARVEL  | ELLIOTT          |   | JANUARY 14 1969  |   | 2 P   |   |      |
| 3. SEX   | 4. RACE |   | 5. DATE OF BIRTH |   | 6. AGE (in years<br>lost birthday)   |   | IF UNDER 1 YEAR<br>MONTHS DAYS  |   |      |
| MALE   | WHITE   |   | Feb. 13, 1888    |   | 80 YRS.  |   |   |   |      |
| 7a. BIRTHPLACE (State or foreign<br>country)   |         | 7b. CITIZEN OF WHAT COUNTRY?  |                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |   |   |      |
| Delaware   |         | USA   |                  |   |  | Wicomico  |   |   |      |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |                  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |   |      |
| Salisbury  |         | Peninsula General Hospital  |                  | Engineer  |  | Electric  |   |   |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |         | 13b. COUNTY   |                  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER                          |      |
| Maryland   |         | Wicomico  |                  | Fruitland   |  |   |   | Moore Avenue                                    |      |
| 14. FATHER'S NAME  |         | First   | Middle           | Lost  | 15. MOTHER'S MAIDEN NAME   |   | First   | Middle  | Lost |
| William  |         | Thomas  | Elliott          |   | Sallie   |   | ?   | Hopkins   |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)   |         | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)               |                  | 17. INFORMANT<br>Address  |  |   |   |   |      |
| No   |         | 214 07 8515   |                  | LeCompte Funeral Service records  |  |   |   |   |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>4123 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Ventricular Fibrillation</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <u>Arteriosclerotic Heart Disease</u> |         |   |                  |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |   |                  |   |  |   |   |   |      |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |                  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |                  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |   |   |   |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |                  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                         |   |   |   |      |
| 22a. I certify that (I) (the hospital) attended the deceased from JAN 14, 1969, to JAN 14, 1969, that (I) (we) last saw the deceased alive on Jan 14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |         |   |                  |   |  |   |   |   |      |
| 22b. SIGNATURE   |         | 22c. DATE SIGNED  |                  |   | 22d. PHYSICIAN'S NAME (Type)   |   |   |   |      |
| Thomas C. Hill, Jr.  |         | 1-14-69   |                  |   | Thomas C. Hill, Jr., MD  |   |   |   |      |
| 22d. PHYSICIAN'S NAME (Type)   |         | 22e. ADDRESS  |                  |   | 22f. REGISTRAR'S SIGNATURE   |   |   |   |      |
| Thomas C. Hill, Jr., MD  |         | Pine Bluff Road, SALISBURY, Md.   |                  |   | f Charles Judge  |   |   |   |      |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |         | 23b. DATE   |                  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |   | 25a. REC'D BY REGISTRAR<br>DATE                 |      |
| Burial   |         | Jan 17 1969   |                  | Dorchester Memorial Park  |  | Cambridge, Maryland   |   | JAN 17 1969                                     |      |
| 24. FUNERAL DIRECTOR   |         | ADDRESS   |                  | 25b. REGISTRAR'S SIGNATURE  |  | 25c. REGISTRAR'S SIGNATURE  |   |   |      |
| LeCompte Funeral Service, Cambridge, Maryland  |         |   |                  | f Charles Judge   |  |   |   |   |      |

2000

6. *Confidentiality*

001202

switched

Johns Hopkins University

[illegible]

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*(Faint, illegible text)*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |   |  |  |                                |                                   |
|---|--|--|--|---|---|--|--|--------------------------------|-----------------------------------|
| CERTIFICATE OF DEATH  |  |  |  |   |   |  |  |                                |                                   |
| 1. DECEASED-NAME (Type or print)  |  |  | First  | Middle  | Last  | 2a. DATE OF DEATH  |  |                                | 2b. HOUR                          |
| ELIJAH  |  |  |  |   | ELLIOTT   | JANUARY 6 1969   |  |                                | 4 P.M.                            |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS |                                   |
| Male  |  | White  |  | July 10, 1917   |   | 51 YRS.  |  |                                |                                   |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |                                |                                   |
| Md  |  | US   |  |   |   | Vicomico   |  |                                |                                   |
| 1d. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  |                                | 12b. KIND OF BUSINESS OR INDUSTRY |
| Salisbury   |  |  | P.O. Hospital  |   |   | Maintenance  |  |                                | Dubut G                           |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER         |                                   |
| Del   |  | Sussex   |  | Delmar  |   |  |  | Rd 3                           |                                   |
| 14. FATHER'S NAME   |  |  | First  | Middle  | Last  | 15. MOTHER'S MAIDEN NAME   |  |                                | First Middle Last                 |
| E. Raymond  |  |  |  |   | Elliot  | Alma   |  |                                | Tholow                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |   |  | Address  |                                |                                   |
|   |  |  |  | Mabel Elliott   |   |  | Delmar Del   |                                |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |   |  |  |                                |                                   |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |   |   |  |  |                                |                                   |
| 1978 IMMEDIATE CAUSE (a) <u>Carcinoma of liver</u>  |  |  |  |   |   |  |  |                                |                                   |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |   |  |  |                                |                                   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |   |   |  |  |                                |                                   |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |   |  |  |                                |                                   |
| (c)   |  |  |  |   |   |  |  |                                |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |   |  |  |                                |                                   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>          |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                                |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |  |                                |                                   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |  |  |                                |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from 12 25 1968, to 1 6 1969, that (I) (we) last saw the deceased alive on 1-6-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |  |                                |                                   |
| 22b. SIGNATURE  |  |  |  |   | DEGREE  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                | 22c. DATE SIGNED                  |
| William A. Reed   |  |  |  |   |   |  |  |                                | 1-9-69                            |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |   | 22e. ADDRESS  |  |  |                                |                                   |
|   |  |  |  |   |   |  |  |                                |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   |  | 23d. LOCATION (City or Town) (County) (State)  |                                |                                   |
| Burial  |  | 1/9/69   |  | Parker Co   |   |  | Salisbury Vicomico Md  |                                |                                   |
| 24. FUNERAL DIRECTOR  |  |  |  |   | ADDRESS   |  | 25a. REC'D BY REGISTRAR  |                                | 25b. REGISTRAR'S SIGNATURE        |
| William A. Reed   |  |  |  |   | Delmar Del  |  | JAN 13 1969  |                                | Charles Judge                     |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01692

CERTIFICATE OF DEATH

01685

|   |  |  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Addie Melton</b>   |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>JANUARY 24 1969</b>   |  |  | 2b. HOUR<br><b>12 A M</b>  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  |  | 4. RACE<br><b>Negro</b>  |  |  | 5. DATE OF BIRTH<br><b>June 15, 1907</b>  |  |  | 6. AGE (In years last birthday)<br><b>61</b> YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Wicomico</b> Md.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Peninsula General</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Domestic</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Wicomico</b>   |  |  | 13c. CITY OR TOWN<br><b>Parsonsburg</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |  |
| 13e. STREET AND NUMBER<br><b>Box 166 Parsonsburg</b>  |  |  | 14. FATHER'S NAME<br>First Middle Last<br><b>Miles Melton</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Mitt Hicks</b>  |  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service) |  |  |
| 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT<br><b>Chestyn Everett</b>  |  |  | 211 E. 42nd Street<br><b>New York, New York</b>   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 yrs.</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4272 IMMEDIATE CAUSE (a) Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>C. V. D.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)  |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                       |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 15, 1969</b> to <b>Jan 24, 1969</b> , that (I) (we) last saw the deceased alive on <b>1-18-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                          |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |  |  |  |  | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  |  | 22c. DATE SIGNED<br><b>1-24-69</b>   |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |  | 22e. ADDRESS  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>1-27-69</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Acres</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Salisbury Wic. Md.</b>                                 |  |  |
| 24. FUNERAL DIRECTOR<br><b>[Signature]</b>  |  |  |  |  |  | ADDRESS<br><b>Volley's Funeral Home, Salis. Md.</b>   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 3 1969</b>  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |  |  |   |  |  |  |  |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01693

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01686

|  |         |                  |  |   |      |  |      |   |  |  |          |
|--|---------|------------------|--|---|------|--|------|---|--|--|----------|
| 1. DECEASED-NAME<br>(Type or Print)  |         |                  | First Middle Last  |   |      | 2a. DATE KNOWN OF DEATH  |      |   | 2b. HOUR   |  |          |
| LOUISE   |         |                  | A. EWARD   |   |      | Month Day Year   |      |   | 2 M  |  |          |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR                                   |      | IF UNDER 24 HRS.   |      | 2c. DATE PRONOUNCED DEAD  |  |  | 2d. HOUR |
| Female   | White   | Jan. 2, 1898     | 71 YRS.  | MONTHS  | DAYS | HOURS  | MIN. | Month Day Year  |  |  | 1000 M   |
| 7a. BIRTHPLACE (State or foreign country)  |         |                  | 7b. CITIZEN OF WHAT COUNTRY?   |   |      | 8. MARRIED   |      |   | 9. COUNTY OF DEATH                                       |  |          |
| Maryland   |         |                  | USA  |   |      | NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |      |   | WICOMICO Md.   |  |          |
| 10. CITY OR TOWN OF DEATH  |         |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                              |      |   | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |          |
| Powellville  |         |                  | R.D., Pittsville   |   |      | None   |      |   | none   |  |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |                  | 13b. COUNTY  |   |      | 13c. CITY OR TOWN  |      |   | 13d. INSIDE CITY LIMITS?                                 |  |          |
| Maryland   |         |                  | Wicomico   |   |      | Powellville  |      |   | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |
| 14. FATHER'S NAME  |         |                  | 15. MOTHER'S MAIDEN NAME   |   |      | 13e. STREET AND NUMBER   |      |   |  |  |          |
| Thomas Smack   |         |                  | Ida Elizabeth Burbage  |   |      | R.D., Pittsville   |      |   |  |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |                  | 16b. SOCIAL SECURITY NO.   |   |      | 17. INFORMANT  |      |   | ADDRESS  |  |          |
| No   |         |                  | 552-01-7309  |   |      | Mr. Herman E. Perdue, Salisbury, Maryland  |      |   |  |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Chronic congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF   |         |                  |  |   |      |  |      |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| 4270 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)   |         |                  |  |   |      |  |      |   |  | years  |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |                  |  |   |      |  |      |   |  |  |          |
| 19a. DATE OF OPERATION   |         |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? |      |  |      | 20. AUTOPSY?  |  |  |          |
|  |         |                  |  |   |      |  |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |          |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |                  | 21b. TIME OF INJURY Month, Day, Year   |   |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)                                      |      |   |  |  |          |
|  |         |                  | HOUR A.M. P.M. 19  |   |      |  |      |   |  |  |          |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   |      | 21f. LOCATION Street or R.F.D. No.   |      |   | City or Town County State                                |  |          |
|  |         |                  |  |   |      |  |      |   |  |  |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |                  |  |   |      |  |      |   |  |  |          |
| ACTUAL SIGNATURE   |         |                  | M.D.   |   |      | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |      |   | 22b. DATE SIGNED   |  |          |
| EXAMINER'S NAME (Type)   |         |                  | Earl L. Royer, M.D.  |   |      | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |      |   | January 13/1969  |  |          |
|  |         |                  | 409 Camden Ave., Salisbury, Md.  |   |      | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |      |   | ADDRESS (Street, city, town, or county)                  |  |          |
|  |         |                  |  |   |      |  |      |   |  |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         |                  | 23b. DATE  |   |      | 23c. NAME OF CEMETERY OR CREMATORY   |      |   | 23d. LOCATION (City or Town) (County) (State)            |  |          |
| Burial   |         |                  | Jan. 14, 1969  |   |      | St. Johns Cemetery   |      |   | Powellville, Wicomico, Maryland                          |  |          |
| 24. FUNERAL DIRECTOR ADDRESS   |         |                  |  |   |      | 25a. REC'D BY REGISTRAR  |      |   | 25b. REGISTRAR'S SIGNATURE                               |  |          |
| HOLLOWAY & COMPANY, SALISBURY, MARYLAND  |         |                  |  |   |      | DATE: Ni 15 1969   |      |   | Charles Judge  |  |          |

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|                                       |  |                    |  |                 |  |
|---------------------------------------|--|--------------------|--|-----------------|--|
| 1. NAME (Last, First, Middle Initial) |  | 2. GRADE           |  | 3. POSITION     |  |
| 4. ORGANIZATION                       |  | 5. ADDRESS         |  | 6. CITY         |  |
| 7. STATE                              |  | 8. ZIP CODE        |  | 9. COUNTRY      |  |
| 10. TELEPHONE                         |  | 11. FAX            |  | 12. E-MAIL      |  |
| 13. DATE                              |  | 14. TIME           |  | 15. DAY OF WEEK |  |
| 16. MONTH                             |  | 17. YEAR           |  | 18. DECADE      |  |
| 19. CENTURY                           |  | 20. MILLENNIUM     |  | 21. EPOCH       |  |
| 22. ERA                               |  | 23. AGE            |  | 24. SEX         |  |
| 25. RACE                              |  | 26. ETHNICITY      |  | 27. RELIGION    |  |
| 28. OCCUPATION                        |  | 29. EDUCATION      |  | 30. EXPERIENCE  |  |
| 31. SKILLS                            |  | 32. ABILITIES      |  | 33. INTERESTS   |  |
| 34. HOBBIES                           |  | 35. SPORTS         |  | 36. ARTS        |  |
| 37. MUSIC                             |  | 38. LITERATURE     |  | 39. HISTORY     |  |
| 40. SCIENCE                           |  | 41. TECHNOLOGY     |  | 42. ENVIRONMENT |  |
| 43. SOCIETY                           |  | 44. CULTURE        |  | 45. POLITICS    |  |
| 46. ECONOMY                           |  | 47. LAW            |  | 48. MEDICINE    |  |
| 49. AGRICULTURE                       |  | 50. INDUSTRY       |  | 51. COMMERCE    |  |
| 52. TRANSPORTATION                    |  | 53. COMMUNICATIONS |  | 54. ENERGY      |  |
| 55. ENVIRONMENTAL                     |  | 56. SPACE          |  | 57. OCEANS      |  |
| 58. ATMOSPHERE                        |  | 59. CLIMATE        |  | 60. WEATHER     |  |
| 61. SOIL                              |  | 62. WATER          |  | 63. AIR         |  |
| 64. LAND                              |  | 65. SEA            |  | 66. SKY         |  |
| 67. EARTH                             |  | 68. SUN            |  | 69. MOON        |  |
| 70. STARS                             |  | 71. PLANETS        |  | 72. GALAXIES    |  |
| 73. UNIVERSE                          |  | 74. COSMOS         |  | 75. COSMOS      |  |
| 76. COSMOS                            |  | 77. COSMOS         |  | 78. COSMOS      |  |
| 79. COSMOS                            |  | 80. COSMOS         |  | 81. COSMOS      |  |
| 82. COSMOS                            |  | 83. COSMOS         |  | 84. COSMOS      |  |
| 85. COSMOS                            |  | 86. COSMOS         |  | 87. COSMOS      |  |
| 88. COSMOS                            |  | 89. COSMOS         |  | 90. COSMOS      |  |
| 91. COSMOS                            |  | 92. COSMOS         |  | 93. COSMOS      |  |
| 94. COSMOS                            |  | 95. COSMOS         |  | 96. COSMOS      |  |
| 97. COSMOS                            |  | 98. COSMOS         |  | 99. COSMOS      |  |
| 100. COSMOS                           |  | 101. COSMOS        |  | 102. COSMOS     |  |
| 103. COSMOS                           |  | 104. COSMOS        |  | 105. COSMOS     |  |
| 106. COSMOS                           |  | 107. COSMOS        |  | 108. COSMOS     |  |
| 109. COSMOS                           |  | 110. COSMOS        |  | 111. COSMOS     |  |
| 112. COSMOS                           |  | 113. COSMOS        |  | 114. COSMOS     |  |
| 115. COSMOS                           |  | 116. COSMOS        |  | 117. COSMOS     |  |
| 118. COSMOS                           |  | 119. COSMOS        |  | 120. COSMOS     |  |
| 121. COSMOS                           |  | 122. COSMOS        |  | 123. COSMOS     |  |
| 124. COSMOS                           |  | 125. COSMOS        |  | 126. COSMOS     |  |
| 127. COSMOS                           |  | 128. COSMOS        |  | 129. COSMOS     |  |
| 130. COSMOS                           |  | 131. COSMOS        |  | 132. COSMOS     |  |
| 133. COSMOS                           |  | 134. COSMOS        |  | 135. COSMOS     |  |
| 136. COSMOS                           |  | 137. COSMOS        |  | 138. COSMOS     |  |
| 139. COSMOS                           |  | 140. COSMOS        |  | 141. COSMOS     |  |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 45M 1/4/69

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |   |   |   |  |                            |
|--|--|--|--|--|---|---|---|--|----------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |   |   |  |                            |
| 01694  |  |  |  |  |   |   |   |  |                            |
| 01687  |  |  |  |  |   |   |   |  |                            |
| CERTIFICATE OF DEATH   |  |  |  |  |   |   |   |  |                            |
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |  | 2a. DATE OF DEATH   |   |   | 2b. HOUR                                     |                            |
| First Middle Last<br>HELEN LORRAINE GALE   |  |  |  |  | Month Day Year<br>January 21, 1969  |   |   | 2:00 PM                                      |                            |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)   |   | IF UNDER 1 YEAR MONTHS DAYS                  |                            |
| Female   |  | Colored  |  | Nov. 8, 1908   |   | 60 YRS.   |   | IF UNDER 24 HRS. HOURS MIN                   |                            |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |   | Md.  |                            |
| Princess Anne  |  | U.S.A.   |  |  |   | WICOMICO  |   |  |                            |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY            |                            |
| Salisbury  |  |  | Deer's Head State Hospital   |  |   | Domestic  |   | None   |                            |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER  |  |                            |
| Maryland   |  |  | Somerset   |  | Princess Anne   |   | Rt. #1, Box 302   |  |                            |
| 14. FATHER'S NAME First Middle Last  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last  |   |   |  |                            |
| Joseph S. Gale   |  |  |  |  | Daisey E. Cornish   |   |   |  |                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |   | Address   |   |  |                            |
| No.  |  | 213-22-8081  |  | Mrs. Sandra Wallace  |   | -512 Booth St. Salisbury, Md.   |   |  |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                            |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease with uremia  |  |  |  |  |   |   |   | Years  |                            |
| 4122 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |   |   |   |  |                            |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |   |   |   | (b) DUE TO, OR AS A CONSEQUENCE OF           |                            |
|  |  |  |  |  |   |   |   | (c)  |                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |   |   |   |  |                            |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |                            |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                      |   |   |  |                            |
| 22a. I certify that (A) (this hospital) attended the deceased from January 6, 1969, to January 21, 1969, that (A) (we) last saw the deceased alive on January 21, 1969, and that in (X) (a) (an) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. |  |  |  |  |   |   |   |  |                            |
| 22b. SIGNATURE   |  |  |  |  | DEGREE  |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED           |
| A. C. Mitchell, M. D.  |  |  |  |  |   |   |   |  | 1/21/69 Maryland           |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)   |   |  |                            |
| Burial   |  | 1/25/69  |  | Metropolitan   |   | Princess Anne, Som. Md.   |   |  |                            |
| 24. FUNERAL DIRECTOR   |  |  |  |  | ADDRESS   |   | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE |
| Charles H. Ward  |  |  |  |  | Marion Sta., Md.  |   | JAN 27 1969   |  | Charles H. Ward            |

01587

CERTIFICATE OF DEATH

01587

NAME: [illegible] CLINICAL: [illegible] DATE: [illegible] SEX: [illegible]

AGE: [illegible] RACE: [illegible] COLOR: [illegible] SEX: [illegible]

DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible] SEX: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible] SEX: [illegible]

CAUSE OF DEATH: [illegible] SEX: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible] SEX: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible] SEX: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible] SEX: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible] SEX: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible] SEX: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

01695

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01688

# CERTIFICATE OF DEATH

|   |  |  |  |  |      |   |  |   |                                   |  |  |
|---|--|--|--|--|------|---|--|---|-----------------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  | Middle   | Lost | 2a. DATE OF DEATH<br>Month Day Year   |  |   | 2b. HOUR<br>M                     |  |  |
| GERTRUDE L. GREBB   |  |  |  |  |      | JANUARY 16 1969   |  |   |                                   |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |      | 6. AGE (In years lost birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |                                   | IF UNDER 24 HRS.<br>HOURS MIN                                |  |
| F   |  | W.   |  | AUG. 13 1883   |      | 65 YRS.   |  |   |                                   |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | B MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. COUNTY OF DEATH<br>Wicomico Md.  |  |   |                                   |  |  |
| MARYLAND  |  | U.S. A   |  |  |      |   |  |   |                                   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| Salisbury   |  |  | Peninsula General Hospital   |  |      | RETIRED   |  |   | NONE                              |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  |      | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 13e. STREET AND NUMBER                                       |  |
| MARYLAND  |  |  | WORCESTER  |  |      | HARLEVILLE  |  |   |                                   |  |  |
| 14. FATHER'S NAME<br>First Middle Lost  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Lost                                |  |      |   |  |   |                                   |  |  |
| MERRILL LEWIS   |  |  | ELIZABETH LATCHAM.   |  |      |   |  |   |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>Address   |      |   |  |   |                                   |  |  |
| No  |  | No   |  | MRS. ALTON LANSTON HARLEVILLE Md   |      |   |  |   |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerosis Heart Disease</u><br><u>4123</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a).<br>stating the underlying cause last. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |  |  |  |      |   |  |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |      |   |  |   |                                   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |      |   |  |   |                                   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |      |   |  |   |                                   |  |  |
|   |  |  |  |  |      |   |  |   |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-16</u> , 19 <u>69</u> , to <u>1-16</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>1-16</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |  |  |  |      |   |  |   |                                   |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>  |  |  |  |  |      | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>1-16-69</u>  |                                   |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |      | 22e. ADDRESS  |  |   |                                   |  |  |
|   |  |  |  |  |      |   |  |   |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |      | 23d. LOCATION (City or Town) (County) (State)   |  |   |                                   |  |  |
| BURIAL  |  | 1/20/69  |  | OCEAN SIDE   |      | STATON ISLAND N.Y.  |  |   |                                   |  |  |
| 24. FUNERAL DIRECTOR<br><u>Ann A. Burbage Berlin Md</u>   |  |  |  |  |      | 25a. REC'D BY REGISTRAR<br>DATE <u>JAN 21 1969</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |                                   |  |  |

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## CERTIFICATE OF DEATH

01689

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>WICOMICO</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>POWELLVILLE Rural 80 PRS</u>  |   | c. LENGTH OF STAY IN lb<br><u>POWELLVILLE</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   |   | d. STREET ADDRESS<br><u>MT PLEASANT Rural</u>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>CLYDE</u> Middle <u>F.</u> Last <u>HAMMOND</u>   |   | 4. DATE OF DEATH<br>Month <u>JAN.</u> Day <u>17</u> Year <u>1969</u>  |  |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>W</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>JULY 26, 1888</u> 80 yrs.                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>FARMER</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>SELF EMPLOYED</u>   | 9. AGE (In years last birthday)<br><u>80</u> yrs.                                      |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>MT PLEASANT WICOMICO</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>FRED HAMMOND</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>ANNIE BAKER</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |   | 16. SOCIAL SECURITY NO.<br><u>No</u>  |  |
| 17. INFORMANT<br><u>MRS CLYDE F. HAMMOND, MT PLEASANT</u>  |   | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>428X Cardiac Arrest</u><br>DUE TO (b) <u>" myocardial infarction</u><br>DUE TO (c) <u>"</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 yrs</u>                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>68</u> , to <u>1/17</u> , 19 <u>69</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>Dec 1</u> 19 <u>68</u> , and that death occurred at <u>2A</u> M, from causes and on the date stated above.                              |   |   |  |
| 22a. SIGNATURE<br><u>W. B. Smith</u> M.D.  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             | 22b. DATE SIGNED<br><u>1/21/69</u>   |
| 22c. PHYSICIAN'S NAME (Type)   |   | 22d. ADDRESS  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   | 23b. DATE THEREOF<br><u>1/24/69</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>MT. PLEASANT</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>POWELLVILLE Wic. MD</u>            |
| 24. FUNERAL DIRECTOR<br><u>Anne A Barbax Berlin Md</u>   |   | 25a. REC'D BY REGISTRAR<br>DATE <u>JAN 27 1969</u>  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                                     |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01552

CERTIFICATE OF BIRTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove rubber papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|--|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|
| 01697  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  | 01690  |  |  |  |                        |  |  |  |
| 1. DECEASED-NAME (Type or print)   |  |  |  |  |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |  |                        |  |  |  |
| First  |  | Middle   |  | Last   |  | Month  |  | Day  |  | Year                   |  | 10:25 M                                      |  |
| William  |  | A.   |  | Harris Jr.   |  | January  |  | 3  |  | 1969                   |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR MONTHS   |  | IF UNDER 24 HRS. HOURS |  | MIN.   |  |
| male   |  | white  |  | APRIL 23, 1904   |  | 67 YRS.  |  |  |  |                        |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |  |                        |  |  |  |
| Maryland   |  | U.S.A.   |  |  |  | Williams   |  |  |  |                        |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |                        |  |  |  |
| SALISBURY  |  | PENNSULA GENERAL HOSP  |  | OWNER  |  | RESTAURANT   |  |  |  |                        |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |                        |  |  |  |
| Maryland   |  | Worcester  |  | Salisbury  |  |  |  | Rt #1  |  |                        |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)   |  |  |  |  |  |                        |  |  |  |
| William A  |  | Pearl Bailey   |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  |  |                        |  |  |  |
|  |  |  |  | 17. INFORMANT  |  |  |  |  |  |                        |  |  |  |
|  |  |  |  | Mrs William A. Harris Snow Hill MD   |  |  |  |  |  |                        |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  |                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) 4124   |  |  |  |  |  |  |  |  |  |                        |  | 4 days                                       |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardio cerebral  |  |  |  |  |  |  |  |  |  |                        |  | not known                                    |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) vascular disease  |  |  |  |  |  |  |  |  |  |                        |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  |  |  |  |                        |  |  |  |
|  |  |  |  |  |  |  |  |  |  |                        |  |  |  |
| MEDICAL CERTIFICATION  |  |  |  |  |  |  |  |  |  |                        |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                        |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)              |  |  |  |                        |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                 |  |  |  |                        |  |  |  |
|  |  |  |  |  |  | 12/31/1968 to 1/3/1969   |  |  |  |                        |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1/3/1969 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |                        |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  |                        |  | 22c. DATE SIGNED                             |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |  |  |  |  |  |                        |  |  |  |
| 22e. ADDRESS   |  |  |  |  |  |  |  |  |  |                        |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  | 25. REC'D BY REGISTRAR   |  |                        |  |  |  |
| Burial   |  | 1/6/1969   |  | SPEUCE BAPTIST   |  | Snow Hill MD   |  | 1/8/1969   |  |                        |  |  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. ADDRESS   |  | 25b. REC'D BY REGISTRAR  |  | 25c. SIGNATURE   |  |  |  |                        |  |  |  |
| Sualed Brund   |  | Snow Hill MD   |  | DATE   |  |  |  |  |  |                        |  |  |  |

01630

RECEIVED IN THE OFFICE OF THE SECRETARY OF THE ARMY

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## CERTIFICATE OF DEATH

01691

|  |                              |   |   |
|--|------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wicomico</b> MARYLAND  |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fruitland</b>   |                              | c. LENGTH OF STAY IN 1b<br><b>Rruitland</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Cedar Street</b>  |                              | d. STREET ADDRESS<br><b>Cedar Street</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br><b>Elizabeth (Lizzie) L. Henry</b>  |                              | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>22</b> Year <b>19 69</b>  |   |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>C</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 1, 1890</b> |
| 9. AGE (In years last birthday) yrs.<br><b>78</b>  |                              | 10. IF UNDER 1 YEAR Months Days Hours Min.<br>IF UNDER 24 HRS.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>   |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Andrew Horsey</b>  |                              | 14. MOTHER'S MAIDEN NAME<br><b>Angeline Graham</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |                              | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><b>Hilda Dorsey</b>   |                              | Address<br><b>Fruitland, Maryland</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>471X</b> IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Influenza</b> DUE TO<br>(c) <b>Infection</b> |                              |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.<br><b>Hypertension, C.V. Disease - Arteriosclerosis</b>   |                              |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                              | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                              | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1969</b> , to <b>Jan 22, 1969</b> , that (I) (we) last saw the deceased alive on <b>Jan 20, 1969</b> , and that death occurred at <b>3:30 P.M.</b> from causes and on the date stated above.   |                              |   |   |
| 22a. SIGNATURE<br><b>Herbert Semblay</b>   |                              | 22b. DATE SIGNED<br><b>Jan 25, 1969</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>G. Herbert Semblay M.D.</b>   |                              | 22d. ADDRESS<br><b>Salisbury Md</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                              | 23b. DATE THEREOF<br><b>1/25/69</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Acres Cemetery</b>  |                              | 23d. LOCATION (City or Town) (County) (State)<br><b>Salisbury Wicomico Md.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>Clinton S. Stewart</b>  |                              | ADDRESS<br><b>Salis - Md</b>  |   |
| 25a. REG'D BY REGISTRAR<br>DATE<br><b>JAN 28 1969</b>  |                              | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and to any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |  |  |                        |  |
|--|--|--|--|--|--|---|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |  |                        |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |                        |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Florence R. HENRY</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>12</b> Year <b>1969</b>                                       |  |  | 2b. HOUR <b>12 P. M.</b>  |  |  |                        |  |
| 3. SEX <b>FEMALE</b>   |  | 4. RACE <b>negro</b>   |  | 5. DATE OF BIRTH<br><b>May 15, 1912</b>  |  | 6. AGE (In years last birthday) <b>56</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b>5</b> DAYS <b>12</b> HOURS <b>12</b> MIN. |                        |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Delaware</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                      |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Wicomico</b> Md.  |  |  |                        |  |
| 10. CITY OR TOWN OF DEATH <b>Salisbury</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General Hospital</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Domestic</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                                      |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Del.</b>  |  |  | 13b. COUNTY <b>Newcastle</b>   |  | 13c. CITY OR TOWN <b>Townsend</b>                                      |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER |  |
| 14. FATHER'S NAME First <b>Samuel F.</b> Middle <b>Henry</b> Last <b>Henry</b>   |  |  | 15. MOTHER'S MAIDEN NAME First <b>Amanda B.</b> Middle <b>Henry</b> Last <b>Henry</b>                          |  |  |   |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b>  |  |  | 16b. SOCIAL SECURITY NO. <b>---</b>  |  | 17. INFORMANT <b>Emma Mason</b> Address <b>RFD #1 Townsend, Del.</b>   |   |  |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cerebral hemorrhage</b><br><b>4122</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>hypertensive cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs</b><br><b>4 YRS</b> |  |  |  |  |  |   |  |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |  |                        |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)  |  |   |  |  |                        |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State           |   |  |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-12</b> , 19 <b>69</b> , to <b>1-12</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1-12</b> , 19 <b>69</b> , and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |  |                        |  |
| 22b. SIGNATURE <b>John G. Bulkeley, MD</b> DEGREE <b>---</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |  |  | 22c. DATE SIGNED <b>1-12-69</b>  |   |  |  |                        |  |
| 22d. PHYSICIAN'S NAME (Type) <b>John Bulkeley</b>  |  |  |  |  | 22e. ADDRESS <b>Salisbury, Md.</b>                                     |   |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE <b>Jan. 18, 1969</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Pinetree Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State) <b>Townsend, Delaware</b>                                 |  |  |                        |  |
| 24. FUNERAL DIRECTOR <b>Howard C. Stevenson</b> ADDRESS <b>Dover, Del.</b>   |  |  |  |  | 25a. REC'D BY REGISTRAR <b>JAN 23 1969</b> DATE                        |   | 25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>  |  |                        |  |





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A  
45M

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |   |   |  |  |  |  |  |
|--|--|---|---|---|--|--|--|--|--|
| CERTIFICATE OF DEATH   |  |   |   |   |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)<br><b>RUTH ELEANOR HOBSON</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>January</b> Day <b>19</b> Year <b>1969</b>                      |   |  | 2b. HOUR<br><b>10:35 PM</b>  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br><b>Sept. 2, 1901</b>  |  | 6. AGE (In years last birthday)<br><b>67</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                        |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>WICOMICO</b>  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Deer's Head State Hospital</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>House Wife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                                 |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Wicomico</b>  |   | 13c. CITY OR TOWN<br><b>Salisbury</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>405 Pennsylvania Avenue</b>         |  |
| 14. FATHER'S NAME<br>First <b>Christian</b> Middle <b>Brandau</b> Last <b>Brandau</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Helene</b> Middle <b>Frederick</b> Last <b>Frederick</b> |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>Unknown</b>  |   | 17. INFORMANT<br>Address <b>Mr. J. Dallas Hobson, Sec 13</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic melanoma</b><br><b>1729</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 1/2 yrs</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Recurrent CVA</b>  |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that <b>X</b> (this hospital) attended the deceased from <b>January 6, 1969</b> , to <b>January 19, 1969</b> , that <b>X</b> (we) last saw the deceased alive on <b>January 19, 1969</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>X</b> (we) (did) (did not) view the body after death. |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>L. V. Maldve</b>  |  | DEGREE<br><b>M. D.</b>  |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>1/20/69</b><br><b>Maryland</b>                                |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>L. V. Maldve, M. D.</b>   |  | 22e. ADDRESS<br><b>Deer's Head State Hospital, Salisbury,</b>   |   |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>1-22-1969</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parsons Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Salisbury, Maryland</b>          |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Hill Funeral Home</b>   |  |   |   | ADDRESS<br><b>Salisbury, Maryland</b>   |  | 25a. REC'D BY REGISTRAR<br><b>JAN 23 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>            |  |

01-24-52

STATE OF OHIO

01-24-52

|              |                                 |
|--------------|---------------------------------|
| DATE         | 01-24-52                        |
| TIME         | 10:30 AM                        |
| PLACE        | St. Mary's Hospital, Cincinnati |
| DEPARTMENT   | Internal Medicine               |
| PHYSICIAN    | Dr. J. H. Smith                 |
| NURSE        | Miss M. J. Brown                |
| LABORATORY   | Dr. W. H. Jones                 |
| RADIOLOGY    | Dr. R. L. White                 |
| PATHOLOGY    | Dr. T. G. Black                 |
| PHARMACOLOGY | Dr. S. K. Green                 |
| TOXICOLOGY   | Dr. P. M. Blue                  |
| ANTHROPOLOGY | Dr. Q. N. Red                   |
| ENTOMOLOGY   | Dr. U. V. Purple                |
| FLORISTRY    | Dr. X. Y. Gold                  |
| ZOOLOGY      | Dr. Z. W. Silver                |
| ASTROLOGY    | Dr. A. B. Bronze                |
| ALGAE        | Dr. C. D. Copper                |
| MYCOLOGY     | Dr. E. F. Nickel                |
| BOTANY       | Dr. G. H. Tin                   |
| ENTOMOLOGY   | Dr. I. J. Lead                  |
| FLORISTRY    | Dr. K. L. Zinc                  |
| ZOOLOGY      | Dr. M. N. Platinum              |
| ASTROLOGY    | Dr. O. P. Silver                |
| ALGAE        | Dr. Q. R. Gold                  |
| MYCOLOGY     | Dr. S. T. Copper                |
| BOTANY       | Dr. U. V. Nickel                |
| ENTOMOLOGY   | Dr. X. Y. Tin                   |
| FLORISTRY    | Dr. Z. W. Lead                  |
| ZOOLOGY      | Dr. A. B. Zinc                  |
| ASTROLOGY    | Dr. C. D. Platinum              |
| ALGAE        | Dr. E. F. Silver                |
| MYCOLOGY     | Dr. G. H. Gold                  |
| BOTANY       | Dr. I. J. Copper                |
| ENTOMOLOGY   | Dr. K. L. Nickel                |
| FLORISTRY    | Dr. M. N. Tin                   |
| ZOOLOGY      | Dr. O. P. Lead                  |
| ASTROLOGY    | Dr. Q. R. Zinc                  |
| ALGAE        | Dr. S. T. Platinum              |
| MYCOLOGY     | Dr. U. V. Silver                |
| BOTANY       | Dr. X. Y. Gold                  |
| ENTOMOLOGY   | Dr. Z. W. Copper                |
| FLORISTRY    | Dr. A. B. Nickel                |
| ZOOLOGY      | Dr. C. D. Tin                   |
| ASTROLOGY    | Dr. E. F. Lead                  |
| ALGAE        | Dr. G. H. Zinc                  |
| MYCOLOGY     | Dr. I. J. Platinum              |
| BOTANY       | Dr. K. L. Silver                |
| ENTOMOLOGY   | Dr. M. N. Gold                  |
| FLORISTRY    | Dr. O. P. Copper                |
| ZOOLOGY      | Dr. Q. R. Nickel                |
| ASTROLOGY    | Dr. S. T. Tin                   |
| ALGAE        | Dr. U. V. Lead                  |
| MYCOLOGY     | Dr. X. Y. Zinc                  |
| BOTANY       | Dr. Z. W. Platinum              |
| ENTOMOLOGY   | Dr. A. B. Silver                |
| FLORISTRY    | Dr. C. D. Gold                  |
| ZOOLOGY      | Dr. E. F. Copper                |
| ASTROLOGY    | Dr. G. H. Nickel                |
| ALGAE        | Dr. I. J. Tin                   |
| MYCOLOGY     | Dr. K. L. Lead                  |
| BOTANY       | Dr. M. N. Zinc                  |
| ENTOMOLOGY   | Dr. O. P. Platinum              |
| FLORISTRY    | Dr. Q. R. Silver                |
| ZOOLOGY      | Dr. S. T. Gold                  |
| ASTROLOGY    | Dr. U. V. Copper                |
| ALGAE        | Dr. X. Y. Nickel                |
| MYCOLOGY     | Dr. Z. W. Tin                   |
| BOTANY       | Dr. A. B. Lead                  |
| ENTOMOLOGY   | Dr. C. D. Zinc                  |
| FLORISTRY    | Dr. E. F. Platinum              |
| ZOOLOGY      | Dr. G. H. Silver                |
| ASTROLOGY    | Dr. I. J. Gold                  |
| ALGAE        | Dr. K. L. Copper                |
| MYCOLOGY     | Dr. M. N. Nickel                |
| BOTANY       | Dr. O. P. Tin                   |
| ENTOMOLOGY   | Dr. Q. R. Lead                  |
| FLORISTRY    | Dr. S. T. Zinc                  |
| ZOOLOGY      | Dr. U. V. Platinum              |
| ASTROLOGY    | Dr. X. Y. Silver                |
| ALGAE        | Dr. Z. W. Gold                  |
| MYCOLOGY     | Dr. A. B. Copper                |
| BOTANY       | Dr. C. D. Nickel                |
| ENTOMOLOGY   | Dr. E. F. Tin                   |
| FLORISTRY    | Dr. G. H. Lead                  |
| ZOOLOGY      | Dr. I. J. Zinc                  |
| ASTROLOGY    | Dr. K. L. Platinum              |
| ALGAE        | Dr. M. N. Silver                |
| MYCOLOGY     | Dr. O. P. Gold                  |
| BOTANY       | Dr. Q. R. Copper                |
| ENTOMOLOGY   | Dr. S. T. Nickel                |
| FLORISTRY    | Dr. U. V. Tin                   |
| ZOOLOGY      | Dr. X. Y. Lead                  |
| ASTROLOGY    | Dr. Z. W. Zinc                  |
| ALGAE        | Dr. A. B. Platinum              |
| MYCOLOGY     | Dr. C. D. Silver                |
| BOTANY       | Dr. E. F. Gold                  |
| ENTOMOLOGY   | Dr. G. H. Copper                |
| FLORISTRY    | Dr. I. J. Nickel                |
| ZOOLOGY      | Dr. K. L. Tin                   |
| ASTROLOGY    | Dr. M. N. Lead                  |
| ALGAE        | Dr. O. P. Zinc                  |
| MYCOLOGY     | Dr. Q. R. Platinum              |
| BOTANY       | Dr. S. T. Silver                |
| ENTOMOLOGY   | Dr. U. V. Gold                  |
| FLORISTRY    | Dr. X. Y. Copper                |
| ZOOLOGY      | Dr. Z. W. Nickel                |
| ASTROLOGY    | Dr. A. B. Tin                   |
| ALGAE        | Dr. C. D. Lead                  |
| MYCOLOGY     | Dr. E. F. Zinc                  |
| BOTANY       | Dr. G. H. Platinum              |
| ENTOMOLOGY   | Dr. I. J. Silver                |
| FLORISTRY    | Dr. K. L. Gold                  |
| ZOOLOGY      | Dr. M. N. Copper                |
| ASTROLOGY    | Dr. O. P. Nickel                |
| ALGAE        | Dr. Q. R. Tin                   |
| MYCOLOGY     | Dr. S. T. Lead                  |
| BOTANY       | Dr. U. V. Zinc                  |
| ENTOMOLOGY   | Dr. X. Y. Platinum              |
| FLORISTRY    | Dr. Z. W. Silver                |
| ZOOLOGY      | Dr. A. B. Gold                  |
| ASTROLOGY    | Dr. C. D. Copper                |
| ALGAE        | Dr. E. F. Nickel                |
| MYCOLOGY     | Dr. G. H. Tin                   |
| BOTANY       | Dr. I. J. Lead                  |
| ENTOMOLOGY   | Dr. K. L. Zinc                  |
| FLORISTRY    | Dr. M. N. Platinum              |
| ZOOLOGY      | Dr. O. P. Silver                |
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| BOTANY       | Dr. K. L. Nickel                |
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| MYCOLOGY     | Dr. K. L. Tin                   |
| BOTANY       | Dr. M. N. Lead                  |
| ENTOMOLOGY   | Dr                              |

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11 (4)  
45M 1/69

| MARYLAND DEPARTMENT OF HEALTH  |  |  |  |  |  |   |  |  |          |
|--|--|--|--|--|--|---|--|--|----------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |  |          |
| 01701 Item 13 Film 409 2/17/69 kk  |  |  |  |  |  |   |  |  |          |
| 01694  |  |  |  |  |  |   |  |  |          |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |          |
| 1. DECEASED-NAME (Type or print)   |  |  |  | First Middle Last  |  | 2a. DATE OF DEATH   |  |  | 2b. HOUR |
| FRANK N. HOWARD  |  |  |  |  |  | January Month 26, 1969 Year   |  |  | 11:22 AM |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |   | 6. AGE (In years lost birthday)                                      |  | 8. YRS.  |
| Male   |  | White  |  | Oct. 29, 1885  |  |   | 83   |  |          |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |  |          |
| Maryland   |  | U.S.A.   |  |  |  | WICOMICO  |  |  |          |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |          |
| Salisbury  |  | Deer's Head State Hospital   |  |  | sand & gravel business   |   |  |  |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                       |          |
| Maryland   |  | Caroline Donohoe   |  | Greensboro Harlock   |  |   |  | Fisher's Nursing Home                        |          |
| 14. FATHER'S NAME First Middle Last  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last   |  |   |  |  |          |
| Frederick Howard   |  |  |  | Sallie Andrew  |  |   |  |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service   |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address   |  |  |          |
| no   |  |  |  | 215-20-2361  |  | Mrs. Grace McQuay Easton, Md.   |  |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia   |  |  |  |  |  |   |  | 3 days                                       |          |
| 4369 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |  |  |  |   |  | 12 yrs                                       |          |
| (b) Cerebral vascular accident, bilateral hemiplegia   |  |  |  |  |  |   |  |  |          |
| (c)  |  |  |  |  |  |   |  |  |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |  |          |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |  |          |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |  |          |
| 22a. I certify that (I) (this hospital) attended the deceased from December 7, 1960, to January 26, 1969, that I (we) last saw the deceased alive on January 26, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |          |
| 22b. SIGNATURE   |  |  |  | 22c. DATE SIGNED   |  |   |  |  |          |
| A. C. Mitchell   |  |  |  | 1/27/69  |  |   |  |  |          |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  | 22e. ADDRESS   |  | 22f. ADDRESS  |  |  |          |
| A. C. Mitchell, M. D.  |  |  |  | Deer's Head Hospital; Salisbury, Md.   |  | 21801   |  |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)                                     |  |  |          |
| Burial   |  | 1/29/69  |  | Concord Cemetery   |  | Federalburg, RFD.   |  |  |          |
| 24. FUNERAL DIRECTOR   |  |  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |          |
| Harvey Williams - Federalburg, Md.   |  |  |  | JAN 29 1969  |  | Charles Judge   |  |  |          |

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GOPT. R. S. HAL.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <i>William T. HUDSON, Jr.</i>   |  |  | 2a. DATE OF DEATH<br>Month <i>JANUARY</i> Day <i>3</i> Year <i>1969</i>                                |   |  | 2b. HOUR<br><i>3:30</i> M   |  |  |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>white</i>  |  | 5. DATE OF BIRTH<br><i>Nov. 1, 1892</i>   |  | 6. AGE (In years last birthday)<br><i>76</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN           |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Del.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A</i>                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Wicomico</i> Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Salisbury</i>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Rev. Gen. Hosp.</i> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>farmer</i>                        |  | 12b. KIND OF BUSINESS OR INDUSTRY                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Del.</i>  |  | 13b. COUNTY<br><i>Sussex</i>   |  | 13c. CITY OR TOWN<br><i>Selbyville</i>  |  | 13d. INSIDE CITY LIMITS<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                  |  | 13e. STREET AND NUMBER                             |  |
| 14. FATHER'S NAME First Middle Last<br><i>William T. Hodson Sr.</i>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><i>Estella Long Hudson</i>                               |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <i>no</i> (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.<br><i>221-20-1910</i>   |   | 17. INFORMANT<br><i>William R. Hudson</i> Address<br><i>Selbyville, Del.</i> |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |   |  |  |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |   |  |   |  |  |  |
| IMMEDIATE CAUSE (a) <i>Cardiac Standstill</i>   |  |  |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute Myocardial Infarction</i>   |  |  |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASCD</i>  |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>Purpura Uremica = B.I. Bleeding</i>   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>    |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1-2-69</i> to <i>1-3</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1-3</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Joseph C. Fitzgerald</i> M.D. DEGREE   |  |  |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED                                   |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  | 22e. ADDRESS  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><i>Jan. 5, 1968</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Red Men's</i>  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Selbyville, Sussex Del.</i>   |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>Richard T. Watson</i>  |  |  |  | ADDRESS<br><i>Selbyville, Del.</i>  |  | 25a. REC'D BY REGISTRAR<br><i>JAN 1 1969</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i> |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |   |   |   |  |   |  |
|--|--|--|---|---|---|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |   |   |   |  |   |  |
| 01703  |  |  |   |   |   |   |  |   |  |
| 01696  |  |  |   |   |   |   |  |   |  |
| CERTIFICATE OF DEATH   |  |  |   |   |   |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>LOTTIE HUGHES</b>  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>JANUARY 1 1969</b>      |   |   | 2b. HOUR<br>M<br><b>11 A.</b>   |  |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>NEGRO</b>  |   | 5. DATE OF BIRTH<br><b>SEPT 7-1901</b>  |   | 6. AGE (In years last birthday)<br><b>67</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED<br><input type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> WIDOWED<br><input type="checkbox"/> DIVORCED             |   | 9. COUNTY OF DEATH<br><b>Wilcomico</b> Md.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>SALISBURY</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>PENINSULA GEN. Hosp</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired</b>                                 |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Household</b>   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>SOMERSET</b>   |   | 13c. CITY OR TOWN<br><b>Deal Island</b>   |   | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  | 13e. STREET AND NUMBER<br><b>Main Road</b>                      |  |
| 14. FATHER'S NAME First Middle Last<br><b>JOSEPH WESLEY HUGHES</b>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>FLORA HARRIS</b> |   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>Unknown</b>                        |   | 17. INFORMANT<br><b>Throna Carter Deal Island Md.</b>                     |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br><b>4339</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Generalized arterio sclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 wks</b><br><b>yes.</b> |  |  |   |   |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/17</b> , 19 <b>68</b> , to <b>1/1</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>12/16</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Sullivan/Sullivan</b>   |  |  |   | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/1/69</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |   | 22e. ADDRESS  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/5/69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>JOHN WESLEY</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Deal Island Som Md</b>                      |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Leroy Webster Porters Anne</b>  |  |  |   | ADDRESS<br><b>Md</b>  |   | 25a. REC'D BY REGISTRAR<br><b>JAN 10 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Wesley</b>                     |  |

CERTIFICATE OF DEATH

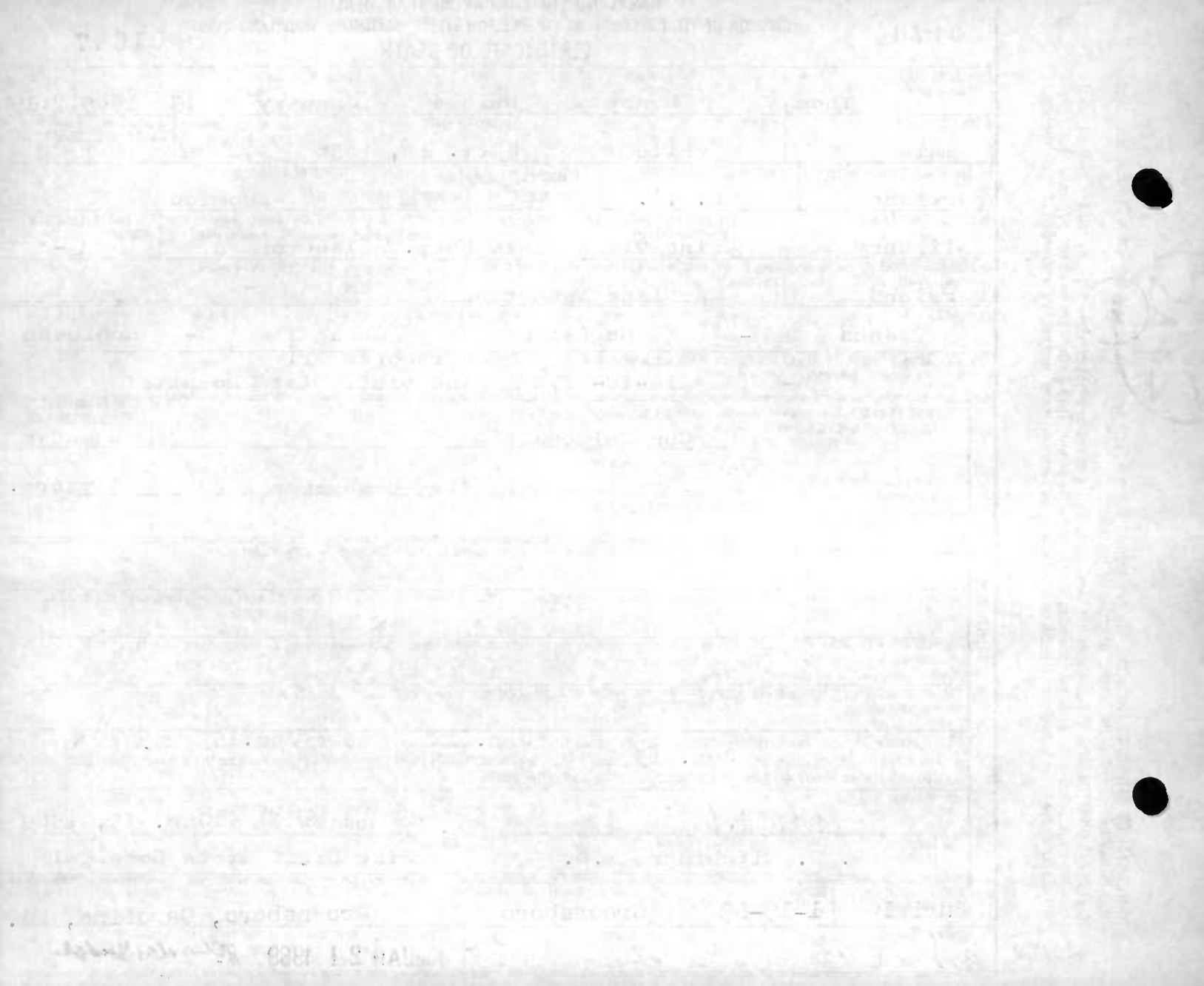
|                        |  |
|------------------------|--|
| Name of Deceased       |  |
| Age                    |  |
| Sex                    |  |
| Date of Death          |  |
| Place of Death         |  |
| Cause of Death         |  |
| Signature of Physician |  |
| Signature of Registrar |  |
| Date of Registration   |  |
| Place of Registration  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M. REV.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |   |   |  |  |   |
|--|--|--|--|---|---|---|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |   |   |  |  |   |
| CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |  |   |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First  | Middle  | Last  | 2a. DATE OF DEATH<br>Month Day Year   |  |  | 2b. HOUR  |
| Thomas   |  |  | Henry  |   | Hughes  | January 15 1969   |  |  | 7:15  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |   |
| male   |  | white  |  | Oct. 10, 1896   |   | 72 YRS.   |  |  |   |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |  | Md.   |
| Maryland   |  | U.S.A.   |  |   |   | Wicomico  |  |  |   |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| Salisbury  |  |  | Pine Bluff State Hosp.   |   |   | laborer   |  |  | -   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER  |
| Maryland   |  |  | Caroline Henderson   |   |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  | -   |
| 14. FATHER'S NAME  |  |  | First  | Middle  | Last  | 15. MOTHER'S MAIDEN NAME  |  |  | First Middle Last   |
| John   |  |  | -  |   | Hughes  | Anna  |  |  | - Robinson  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT   |   |  |  | Address   |
| No   |  |  | 214-10-0772  |   | records of:   |   |  |  | Pine Bluff State Hospital   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cor Pulmonale</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>chronic obstructive emphysema</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u>  |  |  |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>unknown</u><br><u>3 years.</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No.  |   | City or Town   |  | County State  |
| 22a. I certify that (X) (this hospital) attended the deceased from Jan. 12, 19 69, to Jan. 15, 19 69, that (X) (we) lost saw the deceased alive on Jan. 15, 19 69, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |  |  |   |
| 22b. SIGNATURE<br><i>E. P. Ritchings</i>   |  |  |  |   | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br>Jan. 15, 1969  |  |   |
| 22d. PHYSICIAN'S NAME (Type) E. P. Ritchings, M.D.   |  |  |  |   | 22e. ADDRESS<br>Pine Bluff State Hospital   |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)   |  |  |   |
| Burial   |  | 1-19-69  |  | Greensboro  |   | Greensboro, Caroline, Md.   |  |  |   |
| 24. FUNERAL DIRECTOR<br><i>John E. Boulton</i>   |  |  |  |   | ADDRESS<br><i>Greensboro</i>  |   | 25a. REC'D BY REGISTRAR<br>DATE JAN 21 1969  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                                |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 only 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  |
| 01705  |  |  |  |  | 01698  |  |  |  |  |
| 1. DECEASED-NAME (Type or print)   |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |
| ADELL ELIZABETH HURLEY   |  |  |  |  | JANUARY 26 1969 5:30 P.M.  |  |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  | 7. IF UNDER 1 YEAR                           |  |
| Female   |  | White  |  | Oct. 10, 1898  |  | 70   |  | MONTHS DAYS HOURS MIN                        |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |  |
| Virginia   |  | U.S.A.   |  |  |  | WICOMICO Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Salisbury  |  | Peninsula Gen. Hosp.   |  | Housewife  |  | --   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER                       |  |
| Maryland   |  | Worcester  |  | Pocomoke   |  |  |  | R.F.D. 2                                     |  |
| 14. FATHER'S NAME First Middle Last  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                             |  |  |  |  |
| John Douglas East  |  |  |  |  | Ida Jane Justice   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address  |  |  |  |  |  |
| No   |  | none   |  | Robert Hurley, Pocomoke City, Md.  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage   |  |  |  |  |  |  |  | 3 hrs  |  |
| 4310 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral hemorrhage - hypertension  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-26, 1969, to 1-26, 1969, that (I) (we) last saw the deceased alive on 1-26, 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  | 22c. DATE SIGNED   |  |  |  |  |  |
| Frank Weaver M.D. DEGREE   |  |  |  | 1-27-69  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  | 22e. ADDRESS   |  |  |  |  |  |
| Frank Weaver   |  |  |  | Salisbury, Maryland  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |
| Burial   |  | 1-29-1969  |  | Salem Methodist  |  | Pocomoke City-Wor.-Md.   |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                   |  |
| Robert H. Watson   |  |  |  | Pocomoke City, Md.   |  | JAN 30 1969  |  | John H. Jones                                |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |  |  |   |  |  |   |   |  |  |  |  |   |  |  |                                       |  |  |                     |  |  |
|--|--|--|---|--|--|---|--|--|---|---|--|--|--|--|---|--|--|---------------------------------------|--|--|---------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |  |  |   |  |  |   |   |  |  |  |  |   |  |  |                                       |  |  |                     |  |  |
| CERTIFICATE OF DEATH   |  |  |   |  |  |   |  |  |   |   |  |  |  |  |   |  |  |                                       |  |  |                     |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First<br>IDA  |  |  | Middle<br>MAE (ARVEY HARRINGTON)  |  |  | Last<br>HURLEY  |   |  | 2a. DATE OF DEATH<br>Month<br>January  |  |  | Day<br>9                                |  |  | Year<br>1969                          |  |  | 2b. HOUR<br>2:57P M |  |  |
| 3. SEX<br>Female   |  |  | 4. RACE<br>white  |  |  | 5. DATE OF BIRTH<br>July 27, 1887   |  |  | 6. AGE (In years<br>last birthday)<br>81 YRS.   |   |  | IF UNDER 1 YEAR<br>MONTHS  |  |  | IF UNDER 24 HRS.<br>DAYS                |  |  | HOURS                                 |  |  | MIN                 |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>WICOMICO Md.  |   |  |  |  |  |   |  |  |                                       |  |  |                     |  |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Peninsula General Hospital |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Seamstress  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Shift Factory   |   |  |  |  |  |   |  |  |                                       |  |  |                     |  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br>Maryland   |  |  | 13b. COUNTY<br>Wicomico   |  |  | 13c. CITY OR TOWN<br>Salisbury  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  | 13e. STREET AND NUMBER<br>109 E. Locust Street                               |  |  |   |  |  |                                       |  |  |                     |  |  |
| 14. FATHER'S NAME<br>First<br>James  |  |  | Middle<br>H.  |  |  | Last<br>Morgan  |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br>Susan  |   |  | Middle<br>V.   |  |  | Last<br>Dunn                            |  |  |                                       |  |  |                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>220-10-9870A  |  |  | 17. INFORMANT (Daughter)<br>Mrs. Mary Jane Dashiell, Bivalve, Maryland  |  |  |   |   |  |  |  |  |   |  |  |                                       |  |  |                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>1990 Hemorrhage wound at groin</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b) <u>Unrepaired carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>pro</u> |  |  |   |  |  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>pro</u> |  |  |  |  |   |  |  |                                       |  |  |                     |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |   |  |  |   |  |  |   |   |  |  |  |  |   |  |  |                                       |  |  |                     |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?      |  |  |   |  |  |                                       |  |  |                     |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  |   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)                 |   |  |  |  |  |   |  |  |                                       |  |  |                     |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                               |  |  |   |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                    |   |  |  |  |  |   |  |  |                                       |  |  |                     |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11:45</u> , 19 <u>69</u> , to <u>1:45</u> , 19 <u>69</u> , that (I) (we) last<br>saw the deceased alive on <u>11:45</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.                           |  |  |   |  |  |   |  |  |   |   |  |  |  |  |   |  |  |                                       |  |  |                     |  |  |
| 22b. SIGNATURE<br><u>Dr. Henry A. Briele</u>   |  |  |   |  |  | DEGREE  |  |  | ATTENDING<br>PHYS. <input type="checkbox"/>   |   |  | MED.<br>DIRECTOR <input type="checkbox"/>                                    |  |  | STAFF<br>PHYS. <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br>January 10 / 1969 |  |  |                     |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>Dr. Henry A. Briele   |  |  |   |  |  | 22e. ADDRESS<br>Medical Center, Salisbury, Maryland   |  |  |   |   |  |  |  |  |   |  |  |                                       |  |  |                     |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  |  | 23b. DATE<br>Jan. 12, 1969  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Bivalve Church Cemetery   |  |  |   |   |  | 23d. LOCATION (City or Town) (County) (State)<br>Bivalve, Wicomico, Maryland |  |  |   |  |  |                                       |  |  |                     |  |  |
| 24. FUNERAL DIRECTOR<br>HOLLOWAY & COMPANY, SALISBURY, MARYLAND  |  |  |   |  |  |   |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE JAN 14 1969                   |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u> |  |   |  |  |                                       |  |  |                     |  |  |

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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                              |  |   |  |   |                                 |  |   |  |
|---|--|------------------------------|--|---|--|---|---------------------------------|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                              |  |   |  |   |                                 |  |   |  |
| 01707   |  |                              |  |   | 01700  |   |                                 |  |   |  |
| CERTIFICATE OF DEATH  |  |                              |  |   |  |   |                                 |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |                              | First  | Middle  | Last   | 2a. DATE OF DEATH   |                                 |  | 2b. HOUR  |  |
| SADIE   |  |                              | ----   |   | INSLEY                                       | January <sup>Month</sup> 23 <sup>Day</sup> 1969   |                                 |  | 1:20A M   |  |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH  |  |   | 6. AGE (In years last birthday) |  | IF UNDER 1 YEAR<br>MONTHS DAYS                              |  |
| Female  |  | White                        |  | Oct. 9, 1899  |  |   | 69 YRS.                         |  | IF UNDER 24 HRS.<br>HOURS MIN                               |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH              |  |   |  |
| Maryland  |  | USA                          |  |   |  |   | WICOMICO Md.                    |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                           |  |
| Salisbury   |  |                              | Peninsula General Hospital   |   |  | House wife  |                                 |  | ---   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |                              | 13b. COUNTY  |   | 13c. CITY OR TOWN                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                 | 13e. STREET AND NUMBER   |   |  |
| Maryland  |  |                              | Wicomico   |   | Salisbury                                    |   |                                 | 203 E. Locust Street   |   |  |
| 14. FATHER'S NAME   |  |                              | First  | Middle  | Last   | 15. MOTHER'S MAIDEN NAME  |                                 |  | First Middle Last   |  |
| Marion  |  |                              | F.   |   | Morris                                       | Laura   |                                 |  | Brumbley  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no or unknown  |  |                              | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT (Son-in-law)                   |   |                                 |  | Address   |  |
| No  |  |                              | 213-14-1678  |   | Mr. John F. Reichenberg, Salisbury, Maryland |   |                                 |  | 419 Prince St.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac tamponade 2° to</u><br><u>441.0</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>dissecting aortic aneurysm.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                              |  |   |  |   |                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 Hr</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>THORACOTOMY - NON-SUCCESSFUL</u>   |  |                              |  |   |  |   |                                 |  |   |  |
| 19a. DATE OF OPERATION  |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  | 20a. AUTOPSY?   |                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 1-23-69   |  |                              | Aortic Aneurysm  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                 | YES  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                 |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                 |  |   |  |
|   |  |                              |  |   |  |   |                                 |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-23, 1969</u> , to <u>1-23, 1969</u> , that (I) (we) last saw the deceased alive on <u>1-23, 1969</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.  |  |                              |  |   |  |   |                                 |  |   |  |
| 22b. SIGNATURE<br><u>Nevins W. Todd, Jr.</u>  |  |                              |  |   |  | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                 | 22c. DATE SIGNED<br>January 24 / 1969                                |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Dr. Nevins W. Todd, Jr.   |  |                              |  |   |  | 22e. ADDRESS<br>Medical Center, Salisbury, Maryland   |                                 |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |                              | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY           |   |                                 | 23d. LOCATION (City or Town) (County) (State)                        |   |  |
| Burial  |  |                              | 1/25/69  |   | Wicomico Memorial Park                       |   |                                 | Salisbury, Wicomico, Maryland  |   |  |
| 24. FUNERAL DIRECTOR<br>HOLLOWAY & COMPANY, SALISBURY, MARYLAND   |  |                              |  |   |  | 25a. REC'D BY REGISTRAR<br>JAN 27 1969  |                                 | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                     |   |  |



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01708

CERTIFICATE OF DEATH

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|   |  |  |  |   |   |   |  |   |  |
|---|--|--|--|---|---|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print)<br>First Middle Last<br><b>Elsie Virginia Ireland</b>   |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>1-4-69</b>                   |   |   | 2b. HOUR<br><b>10<sup>15</sup> A M</b>  |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Cauc.</b>  |  | 5. DATE OF BIRTH<br><b>3-10-87</b>  |   | 6. AGE (In years last birthday)<br><b>81</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Wicomico</b> Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Wicomico Nursing Home</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>                 |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Wicomico</b>   |  | 13c. CITY OR TOWN<br><b>Salisbury</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>Cartwright Avenue</b>              |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>JARVIS DICKINSON</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>MARGARET Smyth</b> |   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br><b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>219-16-7519</b>                         |   | 17. INFORMANT<br><b>Mrs. MARK P. WOOD</b>   |   | Address<br><b>206 SHEFFIELD AVE SALISBURY, MD</b>                    |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br><b>471X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Influenza</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 WK</b><br><b>1 WK</b> |  |  |  |   |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-1-69</b> , 19 <b>69</b> , to <b>1-4</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1-4</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Mark P. Wood</b> M.D.<br>DEGREE  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |   | 22c. DATE SIGNED<br><b>1-4-69</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>F. L. WEAVER, JR.</b>  |  |  |  | 22e. ADDRESS<br><b>SALISBURY MD</b>   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1/6/1969</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARSONS CEMETERY</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>SALISBURY Wico. MD</b>                      |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>HILL FUNERAL HOME SALISBURY</b>  |  |  |  | ADDRESS   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 8 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>W. L. Jones</b>                |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers, Pages 2 and 3, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |  |   |  |  |  |
| 01703  |  |   |  |   | 01702  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |   |  |   | 2a. DATE OF DEATH  |   |  |  |  |
| First Middle Last<br>Martin Elwood Jacobs  |  |   |  |   | Month Day Year<br>JANUARY 6 1969   |   |  |  |  |
| 2b. HOUR<br>6:20 PM  |  |   |  |   |  |   |  |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>Negro  |  | 5. DATE OF BIRTH<br>May 5, 1888   |  | 6. AGE (In years<br>lost birthday)<br>80 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN     |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Wicomico Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Peninsula Gen'l Hosp. |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Day Laborer |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Farm |  |
| 13a. USUAL RESIDENCE (Where deceased lived,<br>if institution: Residence before<br>admission) STATE<br>Maryland  |  | 13b. COUNTY<br>Wicomico   |  | 13c. CITY OR TOWN<br>Mardela  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | 13e. STREET AND NUMBER<br>RFD #1, Box 113    |  |
| 14. FATHER'S NAME First Middle Last<br>W. Asbury Jacobs  |  |   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Martha (maiden name unknown)   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>221-18-3081   |  | 17. INFORMANT Address<br>Leroy E. Jacobs, Mardela, Md. RFD #1, Bx113  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>486x DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 week |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Coronary Artery Disease</u>  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>1/5/69   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/5/69 to 1/6/69, that (I) (we) last saw the deceased alive on 1/6/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  |   |  |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Frampton   |  |   |  |   | 22e. ADDRESS<br>Frampton Funeral Home, Federalsburg, Md.   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>1-10-1969  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Zion Church Cemetery  |  | 23d. LOCATION (City or Town) (County) (State)<br>Nr. Sharptown, Wicomico, Md.                             |  |  |  |
| 24. FUNERAL DIRECTOR<br>Frampton   |  |   |  |   | 25a. REC'D BY REGISTRAR<br>JAN 22 1969   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                     |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

|  |  |   |   |   |  |   |  |   |  |
|--|--|---|---|---|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Beulah Johnson</b>  |  |   | 2a. DATE OF DEATH<br>1 Month 7 Day 69 Year    |   |  | 2b. HOUR<br>7:00 P  |  |   |  |
| 3. SEX<br><b>female</b>  |  | 4. RACE<br><b>Negro</b>   |   | 5. DATE OF BIRTH<br><b>May 1, 1906</b>  |  | 6. AGE (In years<br>lost birthday)<br><b>62</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Wicomico</b> Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Deer's Head</b> |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Own Home</b>   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived,<br>admission) STATE <b>Maryland</b>  |  | 13b. CITY OR TOWN<br><b>Worcester</b>   |   | 13c. CITY OR TOWN<br><b>Whaleysville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER  |  |
| 14. FATHER'S NAME<br><b>John Brown</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br><b>Osha Evans</b> |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or (unknown) <b>XX</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>XX</b>   |   | 17. INFORMANT<br><b>Irving Johnson</b> Address <b>Whaleysville, Md.</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br><b>4121</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral vascular accident</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertensive arteriosclerotic heart disease</b> |  |   |   |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>9 months</b><br><b>Years</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Bilateral blindness due to optic nerve atrophy</b>   |  |   |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                       |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 5</b> , 19 <b>68</b> , to <b>Jan. 7</b> , 19 <b>69</b> , that (I) (we) lost<br>saw the deceased alive on <b>Jan. 7</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Andrew C Mitchell</b>   |  |   |   | DEGREE ATTENDING<br>PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/>                |  | 22c. DATE SIGNED<br><b>Jan. 8, 1969</b>   |  |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>A. C. Mitchell, M. D.</b>   |  |   |   | 22e. ADDRESS <b>Deer's Head State Hospital<br/>Salisbury, Maryland</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE<br><b>1/11/69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cool Spring</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Girdle tree Md</b>                          |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Edgar Whaley</b>  |  |   |   | ADDRESS<br><b>Salisbury, Md.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JAN 13 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |         |  |                          |   |  |  |  |   |  |
|---|---------|--|--------------------------|---|--|--|--|---|--|
| 01711 CERTIFICATE OF DEATH 01704  |         |  |                          |   |  |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)   |         |  | First Middle Last        |   |  | 2a. DATE OF DEATH  |  |   | 2b. HOUR   |
| ARTHUR WETMORE JONES  |         |  |                          |   |  | Month Day Year   |  |   | 11:15 A M  |
| 3. SEX  | 4. RACE |  | 5. DATE OF BIRTH         |   |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN |  |
| MALE  | WHITE   |  | OCT 20/1891              |   |  | 77 YRS.  |  |   |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |   |  |
| Brooklyn, N.Y.  |         | U S A  |                          |   |  | Wicomico Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          |   |  | 12a. USUAL OCCUPATION (Kind of work done during last week, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY                     |  |
| Salisbury   |         | Peninsula General Hospital   |                          |   |  | Advertising & Executive  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)   |         | 13b. CITY OR TOWN  |                          | 13c. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER   |  |   |  |
| Delaware  |         | Seaford Del.   |                          | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 1001 Middleford Rd   |  |   |  |
| 14. FATHER'S NAME   |         |  | 15. MOTHER'S MAIDEN NAME |   |  |  |  |   |  |
| First Middle Last   |         |  | First Middle Last        |   |  |  |  |   |  |
| (Unk)   |         |  | JONES                    |   |  | (Unk)  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |         |  | 16b. SOCIAL SECURITY NO. |   | 17. INFORMANT  |  |  |   |  |
| Unk   |         |  | 064-01-6518A             |   | Ruth Green Jones (Wife) Address<br>1001 Middleford Rd. Seaford, Delaware   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive Heart Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>402X</u> |         |  |                          |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>20 hrs</u><br><u>2 months</u><br><u>Not known</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |  |                          |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |   | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
|   |         |  |                          |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |
|   |         |  |                          |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/7/69</u> , to <u>1/10/69</u> , that (I) (we) last saw the deceased alive on <u>1/10/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |         |  |                          |   |  |  |  |   |  |
| 22b. SIGNATURE  |         |  |                          |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED   |   |  |
| Dr. O. J. Burton  |         |  |                          |   |  |  | Jan. 10/1969   |   |  |
| 22d. PHYSICIAN'S NAME (Type)  |         |  |                          |   | 22e. ADDRESS   |  |  |   |  |
|   |         |  |                          |   | Medical Center Salisbury, Md. 21801  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION (City or Town) (County) (State)                        |   |  |
| Burial  |         | Jan. 15/1969   |                          | Fair Ridge Cemetery   |  |  | Chappaque, New York  |   |  |
| 24. FUNERAL DIRECTOR  |         |  |                          |   | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |   |  |
| HOLLOWAY & COMPANY SALISBURY, MARYLAND 21801  |         |  |                          |   | DATE   |  | JAN 14 1969  |   |  |





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |         |  |  |  |                                |   |   |   |   |
|---|---------|--|--|--|--------------------------------|---|---|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |  |  |  |                                |   |   |   |   |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |  |  |  |                                |   |   |   |   |
| 1. DECEASED-NAME<br>(Type or Print)   |         |  | First  |  | Middle                         |   | Last  |   |   |
| CLARA   |         |  | ELIZABETH  |  | JONES                          |   |   |   |   |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (in years last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS |   | IF UNDER 24 HRS.<br>HOURS MIN.  |   | 2a. DATE KNOWN OF DEATH<br>Month Day Year             |
| F   | W       | 4-30-1891  |  | 77 YRS.  |                                |   |   |   | 1-4-69 19   |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. COUNTY OF DEATH  |   |   |   |
| 88 NEW VILLE MD   |         | U.S.A.   |  |  |                                | Wicomico  |   |   |   |
| 10. CITY OR TOWN OF DEATH   |         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| Salisbury   |         |  | Peninsula General  |  |                                | HOUSE WIFE  |   | OWN HOME  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |  | 13b. COUNTY  |  | 13c. CITY OR TOWN              |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER                                |
| Md.   |         |  | Wicomico   |  | Salisbury                      |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |   | 412 E. Vine St.                                       |
| 14. FATHER'S NAME   |         |  | First  |  | Middle                         |   | Last  |   |   |
| WARNER  |         |  | BARGER   |  | JANIE                          |   |   | LEWIS(?)  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT                  |   |   | ADDRESS   |   |
| No  |         |  | No   |  | MR. CHARLES JONES              |   |   | SALISBURY MD.   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br><u>4109</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |         |  |  |  |                                |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>hours |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         |  |  |  |                                |   |   |   |   |
| 19a. DATE OF OPERATION  |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M.                    |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                                |   |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No.   |                                | City or Town  |   | County  | State   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |  |  |                                |   |   |   |   |
| ACTUAL SIGNATURE  |         | EXAMINER'S NAME (Type)   |  | 22b. DATE SIGNED   |                                |   |   |   |   |
| <u>Earl L. Royer, M.D.</u>  |         | 409 Camden Ave., Salisbury, Md.  |  | Jan. 6, 1969   |                                |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                                | 23d. LOCATION (City or Town) (County) (State)   |   |   |   |
| BURIAL  |         | 1/8/69   |  | MT. ZION   |                                | POWELLVILLE VILLE MD  |   |   |   |
| 24. FUNERAL DIRECTOR  |         |  |  | ADDRESS  |                                | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE  |   |
| Burbage Funeral Home, Berlin, Md.   |         |  |  |  |                                | JAN 9 1969  |   | <u>Charles Judge</u>  |   |

1

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |               |   |   |   |   |  |   |   |  | 01706   |  |
|---|---------------|---|---|---|---|--|---|---|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |               |   |   |   |   |  |   |   |  | 01713   |  |
| 1. DECEASED-NAME<br>(Type or Print)   |               |   | First<br>HENRY  |   | Middle<br>NEAL  |  | Last<br>JONES   |   |  | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> Month Day Year 1-27-69, 19:46 AM |  |
| 3. SEX<br>M   | 4. RACE<br>AA | 5. DATE OF BIRTH<br>7-9-41  |   | 6. AGE (in years last birthday)<br>27 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS                                  |  | IF UNDER 24 HRS.<br>HOURS MIN   |   | 2c. DATE PRONOUNCED DEAD<br>Month 1 Day 27 Year 1969 |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |               | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Wicomico Md  |   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Fruitland  |               |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Fruitland |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Labor |   |   | 12b. KIND OF BUSINESS OR INDUSTRY                    |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |               |   | 13b. COUNTY<br>Wicomico   |   | 13c. CITY OR TOWN<br>Salisbury                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br>110 Small St.              |   |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Herbert Jones   |               |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Aline Neal                               |   |   |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>no   |               |   | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)                         |   | 17. INFORMANT<br>ADDRESS<br>Herbert Jones R.F.D.1 Salisbury Md. |  |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hemorrhage due to contusion of lower chest and abdomen<br>8160<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |               |   |   |   |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>minutes   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |               |   |   |   |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |               |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |               | 21b. TIME OF INJURY Month, Day, Year<br>1:48 P.M. 1-27-69                               |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Driver of auto that ran off road.  |   |  |   |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK   |               | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br>highway |   | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>Rt. 13, north of Fruitland, Wic., Md.   |   |  |   |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |               |   |   |   |   |  |   |   |  |   |  |
| ACTUAL EXAMINER'S NAME (Type)   |               | Earl L. Royer, M.D.   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                         |  | 22b. DATE SIGNED<br>Jan. 28, 1969   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |               | Burial  |   | 23b. DATE<br>1/30/69  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Acres  |   | 23d. LOCATION (City or Town) (County) (State)<br>Salisbury Wicomico Md.             |  |   |  |
| 24. FUNERAL DIRECTOR<br>Clinton Stewart, Salisbury, Md.   |               |   |   | 25a. REC'D BY REGISTRAR<br>DATE FEB 7 1969  |   |  |   | 25b. REGISTRAR'S SIGNATURE  |  |   |  |

X

X

*Robert A. Thayer*

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |         |                              |  |  |   |   |   |   |                        |  |
|---|---------|------------------------------|--|--|---|---|---|---|------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |                              |  |  |   |   |   |   |                        |  |
| 1. DECEASED-NAME<br>(Type or Print)   |         |                              | First Middle Last  |  |   | 2a. DATE KNOWN OF DEATH   |   | 2b. HOUR  |                        |  |
| LAURA VIRGINIA JONES  |         |                              |  |  |   | Month Day Year<br>1/21 1969   |   | 7:05 P.M.   |                        |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS   |   | IF UNDER 24 HRS.<br>HOURS MIN.  |   | 2c. DATE PRONOUNCED DEAD                                      |                        |  |
| Female  | White   | March 3, 1896                | 72 YRS.  |  |   |   |   | Month Day Year<br>January 21 1969                             |                        |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |   | 2d. HOUR  |                        |  |
| Maryland  |         | USA                          |  |  |   | WICOMICO  |   | 7:05 P.M.   |                        |  |
| 10. CITY OR TOWN OF DEATH   |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)   |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   | 12b. KIND OF BUSINESS OR INDUSTRY                             |                        |  |
| Salisbury   |         |                              | Peninsula General Hospital   |  |   | Housework   |   | at home   |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET AND NUMBER |  |
| Maryland  |         |                              | Wicomico   |  | Pittsville  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                            |   | R.D. 1                 |  |
| 14. FATHER'S NAME   |         |                              | 15. MOTHER'S MAIDEN NAME   |  |   |   |   |   |                        |  |
| First Middle Last<br>John H. Webb   |         |                              | First Middle Last<br>Mary E. Dennis  |  |   |   |   |   |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         |                              | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |   |   |   |                        |  |
| No  |         |                              |  |  | Mrs. Luella Davis, Address Willards, Md.<br>Mrs. Pauline J. Wimbish, Willards, Maryland<br>(Daughters)        |   |   |   |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Crushed right chest</u><br>814.7<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |         |                              |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>sudden</u> |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         |                              |  |  |   |   |   |   |                        |  |
| 19a. DATE OF OPERATION  |         |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |                        |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |         |                              | 21b. TIME OF INJURY Month, Day, Year<br>6:55 P.M. 1-21-69  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Pedestrian struck by auto. |   |   |   |                        |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br>street Glen & Civic Ave., Salisbury, Wic., Md. |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |                        |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |                              |  |  |   |   |   |   |                        |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)  |         |                              | Earl L. Royer, M. D.<br>409 Camden Ave., Salisbury, Md.  |  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |   | 22b. DATE SIGNED<br>January 23/1969                           |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)                                       |   |                        |  |
| Burial  |         |                              | Jan. 24, 1969  |  | Jones Family Cemetery   |   | Powellville, Wicomico, Maryland   |   |                        |  |
| 24. FUNERAL DIRECTOR ADDRESS<br>HOLLOWAY & COMPANY, SALISBURY, MARYLAND   |         |                              |  |  | 25a. REC'D BY REGISTRAR<br>DATE JAN 27 1969   |   | 25b. REGISTRAR'S SIGNATURE  |   |                        |  |



1007

DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
MEDICAL DEPT.

II

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                              |  |   |                                    |   |   |  |                        |  |      |
|---|--|------------------------------|--|---|------------------------------------|---|---|--|------------------------|--|------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                              |  |   |                                    |   |   |  |                        |  |      |
| CERTIFICATE OF DEATH  |  |                              |  |   |                                    |   |   |  |                        |  |      |
| 01715   |  |                              |  |   |                                    |   |   | 01708  |                        |  |      |
| 1. DECEASED-NAME<br>(Type or print)   |  |                              | First  | Middle  | Last                               | 2a. DATE OF DEATH   |   | 2b. HOUR   |                        |  |      |
| Lee   |  |                              |  |   | Jones                              | Month Day Year<br>January 8 1969  |   | A.M. P.M.<br>12:10   |                        |  |      |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH  |                                    | 6. AGE (In years last birthday)   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                             |                        |  |      |
| Male  |  | Negro                        |  | 1-31-1904   |                                    | 64 YRS.   |   |  |                        |  |      |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH  |   | Md.  |                        |  |      |
| Mt Vernon Md  |  | U.S.A.                       |  |   |                                    | Wicomico  |   |  |                        |  |      |
| 10. CITY OR TOWN OF DEATH   |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                        |  |      |
| Salisbury   |  |                              | Deer's Head State Hospital   |   |                                    |   |   |  |                        |  |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |                              | 13b. COUNTY  |   | 13c. CITY OR TOWN                  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER |  |      |
| Maryland  |  |                              | Somerset   |   | Princess Anne                      |   |   |  | Rt. 1, Box 152         |  |      |
| 14. FATHER'S NAME   |  |                              | First  | Middle  | Last                               | 15. MOTHER'S MAIDEN NAME  |   |  | First                  | Middle   | Last |
| John  |  |                              |  | Henry   | Jones                              | Captoral  |   |  |                        | Jones  |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)   |  |                              | 16b. SOCIAL SECURITY NO.   |   |                                    | 17. INFORMANT   |   |  | Address                |  |      |
| No  |  |                              | 219-07-6425  |   |                                    | Eva J. Jones, Rt. 1, Mt Vernon, Md.   |   |  |                        |  |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u><br>485X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                              |  |   |                                    |   |   |  |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 days |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Diabetes mellitus; chronic lymphatic leukemia; old CVA with rt. hemiparesis</u>  |  |                              |  |   |                                    |   |   |  |                        |  |      |
| 19a. DATE OF OPERATION  |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |                                    | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                        |  |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |   |  |                        |  |      |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |   |  |                        |  |      |
| 22a. I certify that (I) (the physician) attended the deceased from 6/5, 1968, to 1/8, 1969, that (I) (the physician) saw the deceased alive on 1/8, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |                              |  |   |                                    |   |   |  |                        |  |      |
| 22b. SIGNATURE<br><i>E. H. Winnacott</i>  |  |                              |  |   |                                    | 22c. DATE SIGNED<br>1/8/69  |   |  |                        |  |      |
| 22d. PHYSICIAN'S NAME (Type)<br>E. H. Winnacott, M. D.  |  |                              |  |   |                                    | 22e. ADDRESS<br>Deer's Head State Hospital, Salisbury, Md.                              |   |  |                        |  |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |                              | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY |   | 23d. LOCATION (City or Town) (County) (State)                                     |  |                        |  |      |
|   |  |                              | 1-12-69  |   | St. Paul                           |   | Mt. Vernon Somerset, Md.  |  |                        |  |      |
| 24. FUNERAL DIRECTOR<br>William J. Jones, Jr.<br>258 Church St.<br>Princess Anne, Md.   |  |                              |  |   |                                    | 25a. REC'D BY REGISTRAR<br>DATE JAN 16 1969   |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                          |                        |  |      |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

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|   |  |                              |  |  |                                    |  |  |  |                                   |   |              |                  |
|---|--|------------------------------|--|--|------------------------------------|--|--|--|-----------------------------------|---|--------------|------------------|
| 1. DECEASED-NAME<br>(Type or print)   |  |                              | First  | Middle   | Last                               | 2a. DATE OF DEATH<br>Month Day Year  |  |  | 2b. HOUR                          |   |              |                  |
| Norman T. Jones   |  |                              |  |  |                                    | January 19 69  |  |  | 1 12 M                            |   |              |                  |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH   |                                    | 6. AGE (In years<br>last birthday)   |  | IF UNDER 1 YEAR  |                                   | IF UNDER 24 HRS.  |              |                  |
| M   |  | Negro                        |  | 7/17/1904  |                                    | 84 YRS.  |  | MONTHS DAYS  |                                   | HOURS MIN.  |              |                  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY? |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                    | 9. COUNTY OF DEATH   |  |  |                                   |   |              |                  |
| Md  |  | U.S.                         |  |  |                                    | Wicomico Md.   |  |  |                                   |   |              |                  |
| 10. CITY OR TOWN OF DEATH   |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |              |                  |
| 5366bury  |  |                              | P.G. Hospital  |  |                                    | Farmer & Waterman  |  |  |                                   |   |              |                  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN                  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER            |   |              |                  |
| Md  |  |                              | Wicomico   |  | Teterville                         |  |  |  |                                   |   |              |                  |
| 14. FATHER'S NAME   |  |                              | First  | Middle   | Last                               | 15. MOTHER'S MAIDEN NAME   |  |  | First                             | Middle  | Last         |                  |
| George  |  |                              |  |  | Jones                              | Lena   |  |  |                                   |   | Waters       |                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (not a U.S. citizen) (If yes give war or dates of service)  |  |                              | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT                      |  |  | Address  |                                   |   |              |                  |
| No  |  |                              | 217-14-8654  |  | Dorothy Conway                     |  |  | Teterville, Md   |                                   |   |              |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 450X Pulmonary emboli<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)             |  |                              |  |  |                                    |  |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>40 hrs  |              |                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |                              |  |  |                                    |  |  |  |                                   |   |              |                  |
| 19a. DATE OF OPERATION  |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                    | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |   |              |                  |
| 1-16-69   |  |                              | Hemorrhoids  |  |                                    | YES <input type="checkbox"/> NO <input type="checkbox"/>                               |  | yes  |                                   |   |              |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)        |  |  |                                   |   |              |                  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work   |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |                                    | 21f. LOCATION  |  |  | Street or R.F.D. No.              | City or Town  | County State |                  |
|   |  |                              |  |  |                                    |  |  |  |                                   |   |              |                  |
| 22a. I certify that (I) (his hospital) attended the deceased from 1-5, 1969, to 1-19, 1969, that (I) (we) last saw the deceased alive on 1-19, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |  |                                    |  |  |  |                                   |   |              |                  |
| 22b. SIGNATURE  |  |                              |  |  |                                    |  |  | DEGREE   |                                   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |              | 22c. DATE SIGNED |
| James J Hamby   |  |                              |  |  |                                    |  |  |  |                                   |   |              | 1-20-69          |
| 22d. PHYSICIAN'S NAME (Type)  |  |                              |  |  |                                    |  |  | 22e. ADDRESS   |                                   |   |              |                  |
| JAMES HAMBY   |  |                              |  |  |                                    |  |  | 5366bury, Md   |                                   |   |              |                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  |  | 23d. LOCATION (City or Town) (County) (State)                        |                                   |   |              |                  |
| Burial  |  |                              | 1/24/69  |  | Teterville Cem. Teterville, Md     |  |  |  |                                   |   |              |                  |
| 24. FUNERAL DIRECTOR  |  |                              |  |  |                                    |  |  | 25a. REC'D BY REGISTRAR  |                                   | 25b. REGISTRAR'S SIGNATURE  |              |                  |
| C. J. Messias, (Biville), Md  |  |                              |  |  |                                    |  |  | JAN 28 1969  |                                   |   |              |                  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>OLEVIA</b>   |  | First<br><b>ANN</b>   | Middle<br><b>JONES</b>  | 2a. DATE OF DEATH<br>Month<br><b>January</b><br>Day<br><b>5</b><br>Year<br><b>1969</b>                           | 2b. HOUR<br><b>2:15 AM</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br><b>July 17, 1879</b>  |   | 6. AGE (In years<br>last birthday)<br><b>89</b><br>YRS.  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS<br>IF UNDER 24 HRS.<br>HOURS<br>MIN. |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>WICOMICO</b><br>Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Peninsula General Hospital</b> |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>House wife</b> |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                   |
| 13a. USUAL RESIDENCE (Where deceased<br>lived, if institution: Residence before<br>admission) STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Wicomico</b>   | 13c. CITY OR TOWN<br><b>Salisbury</b>   | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>              | 13e. STREET AND NUMBER<br><b>1106 Mt. Hermon Road</b>  |  |
| 14. FATHER'S NAME<br>First<br><b>John</b><br>Middle<br><b>R.</b><br>Last<br><b>Whittington</b>   |  | 15. MOTHER'S MAIDEN NAME<br>First<br><b>Martha</b><br>Middle<br><b>Emily</b><br>Last<br><b>Parsons</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)<br><b>No</b><br>(If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>216-54-8977</b>  |   | 17. INFORMANT (Daughter)<br><b>Mrs. Nellie V. Walston, Salisbury, Maryland</b><br>Address <b>Mt. Hermon Road</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4339</b> IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a).<br>stating the underlying cause<br>lost.<br>(b) <b>generalized arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>Today</b><br><b>yes.</b> |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>arteriosclerosis heart disease</b>   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>                          |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/4/69</b> , 19 <b>58</b> to <b>1/5/69</b> , 19 <b>69</b> , that (I) (we) last<br>saw the deceased alive on <b>1/4/69</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Dr. E. M. Beardsley</b><br>DEGREE<br>ATTENDING<br>PHYS.<br><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>   |  |   |   | 22c. DATE SIGNED<br><b>Jan. 6 / 1969</b>   |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>Dr. E. M. Beardsley</b>  |  | 22e. ADDRESS<br><b>211 Maryland Ave., Salisbury, Maryland</b>   |   |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>Jan. 7, 1969</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wicomico Memorial Park</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Salisbury, Wicomico, Maryland</b>   |   | 25a. REC'D BY REGISTRAR<br><b>14 8 1969</b><br>DATE  |  |
|  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>William J. [Signature]</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

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|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>RUTH</b> First <b>A.</b> Middle <b>JONES</b> Last   |  |   | 2a. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>15</b> Year <b>1969</b> |   |  | 2b. HOUR <b>10</b> PM  |  |
| 3. SEX <b>FEMALE</b>   |  | 4. RACE <b>W</b>  |  | 5. DATE OF BIRTH<br><b>AUG. 16, 1895</b>  |  | 6. AGE (In years lost birthday) <b>73</b> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country) <b>OHIO</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Wicomico</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Peninsula General Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RETIRED</b>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>  |  | 13b. COUNTY <b>WICOM.</b>   |  | 13c. CITY OR TOWN<br><b>OCEAN CITY</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>8th ST</b>  |  | 14. FATHER'S NAME First <b>ALMER</b> Middle <b>ARMSTRONG</b> Last   |  | 15. MOTHER'S MAIDEN NAME First <b>JULIA</b> Middle <b>COLE</b> Last   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO. <b>NO</b>  |  | 17. INFORMANT<br><b>MR. SAMUEL A. BLUE</b> Address <b>CHILLICOTHE</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>492X</b> <b>pulmonary embolism</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>unknown</b> |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-11</b> , 19 <b>69</b> to <b>1-5</b> , 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>1-15</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>W. J. J. J.</b> DEGREE <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |   |  | 22c. DATE SIGNED<br><b>1-16-69</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>W. J. J. J.</b>   |  |   |  | 22e. ADDRESS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>  |  | 23b. DATE<br><b>1/20/69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SILVERBROOK</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>WILMINGTON DEL.</b>                      |  |
| 24. FUNERAL DIRECTOR<br><b>Anna A. Burbage</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>DATE JAN 21 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>William A. Budge</b>  |  |

CERTIFICATE OF DEATH



Respectfully submitted

1-12-11 11-11-11 11-11-11

1-11-11 1-11-11 1-11-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |   |  |   |   |  |  |  |  |
|--|--|---|--|---|--|---|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |  |   |   |  |  |  |  |
| 01719  |  |   |  |   |  |   |   |  |  |  |  |
| CERTIFICATE OF DEATH   |  |   |  |   |  |   |   |  |  |  |  |
| 01712  |  |   |  |   |  |   |   |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |   | First<br><b>GRACE</b>  |   | Middle<br><b>P.</b>  |   | Last<br><b>LONDON</b>   |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>JANUARY 2 1969</b> |  | 2b. HOUR<br><b>8 P. M.</b>                       |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>Feb 1, 1901</b>  |  |   | 6. AGE (In years<br>last birthday)<br><b>67</b><br>YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>67</b>                  |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>8 P. M.</b> |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                      |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Wicomico Somerset</b><br>Md.   |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Pen Gen Hospital</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Registered Nurse</b> |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Nursing</b>       |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived,<br>admission) STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Somerset</b>   |   | 13c. CITY OR TOWN<br><b>Crisfield</b>                                  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>41 Wynfall Ave.</b>             |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>William - Matthews</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Matilda Frances Bell</b>                               |   |  |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes give war or dates of service)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>217-30-7968</b>   |   | 17. INFORMANT<br>Address<br><b>Herman L. Landon, Same as 13. abcde</b> |   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cause hepatitis</b><br><b>5730</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b)<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>4 days</b> |  |   |  |   |  |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Chronic alcoholic liver disease</b>  |  |   |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?          |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12 27</b> , 19 <b>68</b> , to <b>1-2</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Wilber R. Ellis, Jr.</b><br>DEGREE ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>  |  |   |  |   |  | 22c. DATE SIGNED<br><b>1-2-69</b>   |   |  |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>Wilber R. Ellis, Jr.</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>Salisbury, Md.</b>   |   |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>Jan 5, 1969</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunnyridge Cemetery</b>  |  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Crisfield, Somerset, Md.</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>Bradshaw &amp; Sons, Crisfield, Md. 21817</b>  |  |   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>JAN 7 1969</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Jackson</b>                             |  |  |  |

017-112

STATE OF OHIO

017-112

Sealed

132

132

At Court House

County of Franklin

County of Franklin

21-1-1908

21-1-1908

Witness

Witness

Witness

Witness

Witness

Witness

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|
| 01720   |  |  |  |  | 01713   |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  |  |  | 2a. DATE OF DEATH   |  |  | 2b. HOUR                                     |  |
| First   |  | Middle   |  | Last   |   | Month  |  | Day  |  |
| RUTH  |  | *****  |  | LAWS   |   | 1  |  | 22   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR                              |  |
| Female  |  | White  |  | 11-25-1893   |   | 75   |  | MONTHS                                       |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  | IF UNDER 24 HRS. HOURS MIN.                  |  |
| Maryland  |  | U.S.A.   |  |  |   | Wicomico   |  | Md   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Wango   |  | Laws Rd.,  |  | Never Work   |   | Own Home   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER                       |  |
| Maryland  |  | Wicomico   |  | Parsonsborg  |   |  |  | Rt. #1 Laws Rd. Wango                        |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |   |  |  |  |  |
| First   |  | Middle   |  | Last   |   | First  |  | Middle                                       |  |
| James   |  | H.   |  | Laws   |   | Leah   |  | Catherine                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |   | Address  |  |  |  |
| No  |  | 217-36-1167  |  | Mr. Homer Laws, See Sec 13   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4121 Acute myocarditis</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Myocarditis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|   |  |  |  |  |   |  |  | ?  |  |
|   |  |  |  |  |   |  |  | ?  |  |
|   |  |  |  |  |   |  |  | ?  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |
|   |  |  |  |  | 9-1-1968 to 1-22-1969   |  |  |  |  |
| 22a. I certify that (I) (this hospital), attended the deceased from 9-1-1968 to 1-22-1969, that (I) (we) last saw the deceased alive on 1-15-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE <u>Clifford E. Schott MD</u>   |  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED 1-23-1969   |  |  |
| 22d. PHYSICIAN'S NAME (Type) Dr. Clifford E. Schott   |  |  |  |  | 22e. ADDRESS 314 N. Main St., Berlin, Maryland  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |
| Burial  |  | 1-24-1969  |  | Laws Cemetery  |   | Wango, Wicomico, Maryland  |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS Hill Funeral Home, Salisbury, Maryland   |  |  |  |  | 25a. REC'D BY REGISTRAR JAN 27 1969   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |





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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |   |  |  |  |  |
|---|--|---|--|---|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |   |  |  |  |  |
| CERTIFICATE OF DEATH  |  |   |  |   |   |  |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Ruth MAE (MAY) Layfield   |  |   |  |   | 2a. DATE OF DEATH Month Day Year<br>1-28-69   |  |  | 2b. HOUR<br>2:45 PM  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Cauc.  |  | 5. DATE OF BIRTH<br>6-25-87   |   | 6. AGE (In years last birthday)<br>81 YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Wicomico County Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Wicomico Nursing Home |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>House wife |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>---                             |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  | 13b. COUNTY<br>Wicomico   |  | 13c. CITY OR TOWN<br>Salisbury  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>310 Locust Terrace               |  |
| 14. FATHER'S NAME First Middle Last<br>Henry Godfrey  |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Dora Fooks  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No   |  | 16b. SOCIAL SECURITY NO.<br>220-44-2980J  |  | 17. INFORMANT Address (Daughters)<br>Mrs. Evelyn Morris<br>Mrs. Dorothy Perdue, Salisbury, Maryland   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u><br>4409<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Atherosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 day. |  |   |  |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)  |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1968</u> , to <u>1-28</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>1-28</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><u>Dr. Frank L. Weaver</u> MD   |  |   |  | 22c. DATE SIGNED<br>1-28-69   |   | 22d. PHYSICIAN'S NAME (Type)<br>Dr. Frank L. Weaver  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br>Jan. 30, 1969  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parsons Cemetery  |   | 23d. LOCATION (City or Town) (County) (State)<br>Salisbury, Wicomico, Maryland               |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br>HOLLOWAY & COMPANY, SALISBURY, MARYLAND   |  |   |  | 25a. REC'D BY REGISTRAR<br>FEB 3 1969   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  |  |  |

1974

WASH DC 20540

1974

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833 834

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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X

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |   |   |  |  |  |  |  |
|--|--|---|---|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |   |   |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |   |   |   |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <i>Lillian</i>   |  |   | First Middle Last <i>ORME Leach</i>                                 |   |  | 2a. DATE OF DEATH<br>Month Day Year <i>January 30 1969</i>                         |  | 2b. HOUR<br><i>12 25 AM</i>                            |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>   |   | 5. DATE OF BIRTH<br><i>Dec. 13, 1889</i>  |  | 6. AGE (In years last birthday)<br><i>79</i> YRS.                                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.              |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Canada</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Wicomico</i> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Salisbury</i>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Peninsula General Hospital</i> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Housewife</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>--</i>                                     |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Maryland</i>   |  | 13b. CITY OR TOWN<br><i>Pocomoke</i>  |   | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><i>706 Market Street</i>                                 |  |  |  |
| 14. FATHER'S NAME First Middle Last<br><i>Thomas James Livingston Orme</i>   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><i>Edith -- Pacey</i> |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><i>no</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>none</i>   |   | 17. INFORMANT Address<br><i>James C. Leach, Pocomoke City, Md.</i>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><i>1621</i> IMMEDIATE CAUSE (a) <i>Unknown</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Anaplastic carcinoma lung &amp;</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Sarcoma R thigh with fracture of femur</i> |  |   |   |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Richard E. Hughes</i>   |  | DEGREE<br><i>M.D.</i>   |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED<br><i>1/31/69</i>   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>Richard E. Hughes, M.D.</i>   |  | 22e. ADDRESS<br><i>Salisbury, Maryland</i>  |   |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  | 23b. DATE<br><i>2-1-1969</i>  |   | 23c. NAME OF CEMETERY<br><i>Fort Lincoln</i>  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Prince George's County, Md</i> |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>Robert H. Watson</i>  |  |   |   | ADDRESS<br><i>Pocomoke City, Md.</i>  |  | 25a. REC'D BY REGISTRAR<br><i>FEB 5 1969</i>                                       |  | 25b. REGISTRAR'S SIGNATURE<br><i>Richard E. Hughes</i> |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)  
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |   |  |  |  |  |
|---|--|--|--|---|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |   |  |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |   |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  |  |   | 2a. DATE OF DEATH   |  |  | 2b. HOUR   |  |
| First Middle Last<br>Ethel Virginia Lewis   |  |  |  |   | Month Day Year<br>1 14 69   |  |  | 3 4 M  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (In years lost birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                 |  |
| Female  |  | Cauc.  |  | 3/28/90   |   | 78 YRS.  |  | IF UNDER 24 HRS.<br>HOURS MIN.                                 |  |
| 7d. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |  |  |
| Md.   |  | U.S.   |  |   |   | Wicomico Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Salisbury   |  | Wicomico Nursing Home (Booth St)   |  | Housewife   |   | Own Home   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |
| Md.   |  | Worcester  |  | Girdletree  |   |  |  |  |  |
| 14. FATHER'S NAME First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last |   |   |  |  |  |  |
| Thomas Tarr   |  |  | Mary Vickers                               |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.                   |   | 17. INFORMANT Address   |  |  |  |  |
| No  |  |  | 217-28-2590                                |   | Mrs. Irene Esterline, Girdletree, Md.   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4409 Congestive heart failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Arteriosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 mo<br>10 yr. |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>          |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/62, 1968, to 1/13, 1969, that (I) (we) last saw the deceased alive on 1-13-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br>[Signature]<br>DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |  |   | 22c. DATE SIGNED<br>1-14-69   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |   | 22e. ADDRESS  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |
| Burial  |  | 1-16-69  |  | Baptist   |   | Girdletree Md  |  |  |  |
| 24. FUNERAL DIRECTOR<br>[Signature]<br>ADDRESS<br>Spoon Hill, Md.   |  |  |  |   | 25a. REC'D BY REGISTRAR<br>JAN 17 1969  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                            |  |  |

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## CERTIFICATE OF DEATH

|  |  |  |  |   |   |  |   |  |                                   |  |      |
|--|--|--|--|---|---|--|---|--|-----------------------------------|--|------|
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First  | Middle  | Last                                    | 2a. DATE OF DEATH<br>Month Day Year  |   |  | 2b. HOUR                          |  |      |
| CLARA  |  |  |  | Beall   | LONG                                    | January 2 1969   |   |  | 10:45                             |  |      |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)  |   | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |                                   | IF UNDER 24 HRS.<br>HOURS MIN                |      |
| Female   |  | White  |  | March 29, 1877  |   | 91 YRS.  |   |  |                                   |  |      |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>WICOMICO Md.   |   |  |                                   |  |      |
| Balto., Md.  |  | USA  |  |   |   |  |   |  |                                   |  |      |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |      |
| Salisbury  |  |  | Springhill Sanitarium, Inc.  |   |   | homemaker  |   |  |                                   |  |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN                       |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER            |  |      |
| Md   |  |  | Wicomico   |   | Salisbury                               |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |  | 516 N. Pinehurst Ave.             |  |      |
| 14. FATHER'S NAME  |  |  | First  | Middle  | Last                                    | 15. MOTHER'S MAIDEN NAME   |   |  | First                             | Middle                                       | Last |
| Robert   |  |  | Clayton  | Beall   |   | Ella   |   |  |                                   | Rand   |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address                   |  |   |  |                                   |  |      |
| no   |  |  |  |   | Mrs. Wade H. Insley, Jr. Salisbury, Md. |  |   |  |                                   |  |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary vascular Renal disease</i><br><i>4122</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |   |  |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |   |  |   |  |                                   |  |      |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |  |      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |   |  |                                   |  |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.  |   | City or Town   |   | County   |                                   | State  |      |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 1967, to 1-2, 1969, that (I) (we) lost the deceased on 1-2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |  |   |  |                                   |  |      |
| 22b. SIGNATURE <i>Philip A. Insley</i>   |  |  |  |   |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED January 3 / 1969                                    |                                   |  |      |
| 22d. PHYSICIAN'S NAME (Type) Dr. Philip A. Insley  |  |  |  |   |   | 22e. ADDRESS 116 E. Main Street, Salisbury, Maryland   |   |  |                                   |  |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town)   |   | (County)   |                                   | (State)                                      |      |
| burial   |  | 1/6/69   |  | Lorraine Park Cem.  |   | Balto.   |   |  |                                   | Md.  |      |
| 24. FUNERAL DIRECTOR ADDRESS   |  |  |  |   |   | 25a. REGD. BY REGISTRAR DATE   |   | 25b. REGISTRAR'S SIGNATURE   |                                   |  |      |
| Mitchell-Wiedefeld Home 6500 York Rd. #21212   |  |  |  |   |   | JAN 6 1969   |   | <i>Charles Judge</i>   |                                   |  |      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |                          |   |   |   |  |  |                                       |        |      |
|---|--|--|--------------------------|---|---|---|--|--|---------------------------------------|--------|------|
| 01725   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |                          |   |   | 01718   |  |  |                                       |        |      |
| CERTIFICATE OF DEATH  |  |  |                          |   |   |   |  |  |                                       |        |      |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First                    | Middle  | Last  | 2a. DATE OF DEATH<br>Month Day Year           |  | 2b. HOUR<br>M                                |                                       |        |      |
| Jazzie  |  |  | Lee                      |   | MAE   | JANUARY 23, 1969                              |  | 10:45  |                                       |        |      |
| 3. SEX  |  | 4. RACE  |                          | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)               |  | 7. UNDER 1 YEAR<br>MONTHS DAYS               |                                       |        |      |
| FEMALE  |  | Neg Ro   |                          | 11-12-1912  |   | 56 YRS.                                       |  |  |                                       |        |      |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH                            |  | 12b. KIND OF BUSINESS OR INDUSTRY            |                                       |        |      |
| Georgia   |  | United States  |                          |   |   | Wicomico                                      |  |  |                                       |        |      |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   | 12b. KIND OF BUSINESS OR INDUSTRY             |  |  |                                       |        |      |
| Salisbury   |  | Peninsula General  |                          | Domestic  |   |   |  |  |                                       |        |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. CITY OR TOWN  |                          | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET AND NUMBER                        |  |  |                                       |        |      |
| Md.   |  | Worcester  |                          | Newark  |   | Newark, Maryland                              |  |  |                                       |        |      |
| 14. FATHER'S NAME   |  |  | First                    | Middle  | Last  | 15. MOTHER'S MAIDEN NAME                      |  |  | First                                 | Middle | Last |
| William   |  |  | Johnson                  |   | Elmira  | Harris  |  |  |                                       |        |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |  | 16b. SOCIAL SECURITY NO. |   |   | 17. INFORMANT                                 |  |  | 16c. ADDRESS                          |        |      |
|   |  |  | 266-26-4973              |   |   | Reatham Johnson                               |  |  | 716 Waldo Road S.E. Gainesville, Fla. |        |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Left Vent failure due to</u><br><u>4/23</u> <u>Arteriosclerotic Heart Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |                          |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                       |        |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Suspected pulmonary embolism &amp; obesity</u>   |  |  |                          |   |   |   |  |  |                                       |        |      |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                       |        |      |
|   |  |  |                          |   |   |   |  |  |                                       |        |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                          |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |                                       |        |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |                                       |        |      |
|   |  |  |                          |   |   |   |  |  |                                       |        |      |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-23-1969</u> to <u>1-23-1969</u> , that (I) (we) last saw the deceased alive on <u>1-23-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |                          |   |   |   |  |  |                                       |        |      |
| 22b. SIGNATURE <u>James H. Gifford</u>  |  |  |                          |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED <u>1-25-69</u>                                      |  |                                       |        |      |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |                          |   | 22e. ADDRESS  |   |  |  |                                       |        |      |
|   |  |  |                          |   |   |   |  |  |                                       |        |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State) |  |  |                                       |        |      |
| Burial  |  | 1-29-69  |                          | Wms. No   |   | Newark Worcester, Md.                         |  |  |                                       |        |      |
| 24. FUNERAL DIRECTOR<br>Jolley's Funeral Home   |  |  |                          |   | 25a. REG'D BY REGISTRAR<br>FEB 3 1969   |   | 25b. REGISTRAR'S SIGNATURE   |  |                                       |        |      |

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CRIMINAL RECORD

11-11-1918

11-11-1918

United States

California

San Francisco

Domestic

New York

Chicago

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[Faint, mostly illegible text in the main body of the document, possibly containing case details or a list of entries.]

11-11-1918

11-11-1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 1 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |  |   |   |   |
|---|--|--|--|---|--|--|---|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |   |   |   |
| CERTIFICATE OF DEATH  |  |  |  |   |  |  |   |   |   |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Lost<br>CATHERINE MABEL MAGEE   |   |  | 2a. DATE OF DEATH<br>Month Day Year<br>January 16, 1969  |   |   | 2b. HOUR<br>1:40 PM   |
| 3. SEX<br>Female  |  | 4. RACE<br>Colored   |  | 5. DATE OF BIRTH<br>May 7, 1897   |  |  | 6. AGE (In years last birthday)<br>71 YRS.  |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN   |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>WICOMICO Md.   |   |   |   |
| 10. CITY OR TOWN OF DEATH<br>Salisbury  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Deer's Head State Hospital |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housework |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  |  | 13b. COUNTY<br>Caroline  |   | 13c. CITY OR TOWN<br>Federalsburg  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br>304 Denton Road<br>Preston Road X |
| 14. FATHER'S NAME First Middle Lost<br>Winfield -- Magee  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Lost<br>Edith -- Thomas  |   |  |  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>NO  |  |  | 16b. SOCIAL SECURITY NO.<br>218-30-2065  |   | 17. INFORMANT<br>Address<br>Mrs. Charles Magee, Federalsburg, Maryland               |  |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of cervix with extensive metastasis</u><br><u>180X</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 years</u> |  |  |  |   |  |  |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |   |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |   |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |  |   |   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                         |  |   |   |   |
| 22a. I certify that (X) (this hospital) attended the deceased from January 15, 1969, to January 16, 1969, that (I) (we) last saw the deceased alive on January 16, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (XXXX) view the body after death.  |  |  |  |   |  |  |   |   |   |
| 22b. SIGNATURE<br><u>L. V. Maldve</u>   |  |  |  |   | 22c. DATE SIGNED<br>1/16/69<br>Maryland  |  |   |   |   |
| 22d. PHYSICIAN'S NAME (Type)<br>L. V. Maldve, M. D.   |  |  |  |   | 22e. ADDRESS<br>Deer's Head State Hospital, Salisbury,                               |  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>Jan. 25, 1969   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Federal Hill Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Federalsburg, Caroline, Md.                         |   |   |   |
| 24. FUNERAL DIRECTOR<br>J. J. Frampton and Son, Federalsburg, Md.   |  |  |  |   | 25a. RECD. BY REGISTRAR<br>JAN 21 1969   |  | 25b. J. J. Frampton and Son, Federalsburg, Md.  |   |   |

11712

LABORATORY OF THE

11712

January 16, 1989 1:10

NAME

AGE

DATE

SEX

DOB

Color

Height

Weight

Build

Complexion

Scars

Current Address

City

State

Zip

Telephone

Occupation

Notes

Ref

Spec

Result

1-16-89 1:10

1-16-89 1:10

January 16, 1989

1:10

1:10

1:10

1:10

1:10

1:10

1:10

1:10



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01727

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01720

|  |  |                  |                |  |  |  |  |   |                 |                                |  |   |  |   |                     |  |  |
|--|--|------------------|----------------|--|--|--|--|---|-----------------|--------------------------------|--|---|--|---|---------------------|--|--|
| 1. DECEASED-NAME<br>(Type or Print)  |  |                  | First<br>MABLE |  |  | Middle<br>ELLEN  |  |   | Last<br>MAILAND |                                |  | 2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI-<br>DEATH MATED <input type="checkbox"/> Month Day Year<br>Jan. 4 1969 |  |   | 2b. HOUR<br>2:50 M. |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White |                | 5. DATE OF BIRTH<br>Sept. 19, 1909   |  | 6. AGE (in years<br>last birthday)<br>59 YRS.                        |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |                 | IF UNDER 24 HRS.<br>HOURS MIN. |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br>January 4 1969  |  |   | 2d. HOUR<br>2:50 M. |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country) Maryland  |  |                  |                | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                 |                                |  | 9. COUNTY OF DEATH<br>WICOMICO  |  |   |                     |  |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury   |  |                  |                | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Peninsula General Hospital  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>House work  |                 |                                |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>---   |  |   |                     |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE Maryland  |  |                  |                | 13b. COUNTY<br>Wicomico  |  |  |  | 13c. CITY OR TOWN<br>Salisbury  |                 |                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br>R.D. 5, Spring Hill Road      |                     |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Ulysses Upton Wilson   |  |                  |                |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Lucy Ellen Phillips |  |   |                 |                                |  |   |  |   |                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No  |  |                  |                | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>215-03-3275   |  |  |  | 17. INFORMANT (Husband) R.D. 5 ADDRESS Spring Hill Road<br>Mr. John Mailand, Salisbury, Maryland  |                 |                                |  |   |  |   |                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                  |                |  |  |  |  |   |                 |                                |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>days |                     |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |                  |                |  |  |  |  |   |                 |                                |  |   |  |   |                     |  |  |
| 19a. DATE OF OPERATION   |  |                  |                | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?   |  |  |  |   |                 |                                |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |                     |  |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |  |                  |                | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                 |                                |  |   |  |   |                     |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE<br>AT WORK <input type="checkbox"/>   |  |                  |                | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                 |                                |  |   |  |   |                     |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |                  |                |  |  |  |  |   |                 |                                |  |   |  |   |                     |  |  |
| ACTUAL<br>SIGNATURE<br>EXAMINER'S<br>NAME (Type)<br>Earl L. Royer, M.D.<br>409 Camden Ave., Salisbury, Md.   |  |                  |                | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ADDRESS (Street, city, town, or county) |  |  |  | 22b. DATE SIGNED<br>January 6/1969  |                 |                                |  |   |  |   |                     |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  |                  |                | 23b. DATE<br>Jan. 6, 1969  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Springhill Memory Gardens   |                 |                                |  | 23d. LOCATION (City or Town) (County) (State)<br>Salisbury, Wicomico, Maryland  |  |   |                     |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br>HOLLOWAY & COMPANY, SALISBURY, MARYLAND   |  |                  |                |  |  |  |  | 25a. REC'D BY REGISTRAR<br>JAN 8 1969   |                 |                                |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |   |                     |  |  |

1947

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01728

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items#13b, FilmG409 1/31/69 km

## CERTIFICATE OF DEATH

01721

|   |  |  |  |  |  |   |  |  |  |  |  |  |  |                                |  |
|---|--|--|--|--|--|---|--|--|--|--|--|--|--|--------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Caroline</b>   |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>25</b> Year <b>1969</b>   |  |  | 2b. HOUR<br><b>4:45</b>  |  |  |  |  |                                |  |
| 3. SEX<br><b>Female</b>   |  |  | 4. RACE<br><b>White</b>  |  |  | 5. DATE OF BIRTH<br><b>August 2, 1883</b>   |  |  | 6. AGE (In years last birthday)<br><b>85</b> YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                       |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Wicomico</b>  |  |  | Md.  |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury, Md.</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Spring Hill Pvt. Sanitarium</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOMEMAKER</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <b>Md.</b>  |  |  | 13b. COUNTY <b>Worcester</b>   |  |  | 13c. CITY OR TOWN <b>Salisbury</b>  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>714 Riverside Drive</b> |  |                                |  |
| 14. FATHER'S NAME<br><b>Edward B. Jehnert</b>   |  |  | First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>Mary Bachman</b>   |  |  | First Middle Last  |  |  |  |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, (no, or unknown) <b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>214-01-9340D</b>  |  |  | 17. INFORMANT<br><b>Mr. William Mangold</b>   |  |  | Address<br><b>1004 Woodson Rd</b>  |  |  |  |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b><br><b>4124</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>months</b><br><b>year</b> |  |  |  |  |  |   |  |  |  |  |  |  |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |   |  |  |  |  |  |  |  |                                |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |  |  |  |  |  |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                       |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-25</b> , 19 <b>60</b> , to <b>1-25</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1-24</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.  |  |  |  |  |  |   |  |  |  |  |  |  |  |                                |  |
| 22b. SIGNATURE<br><b>Earl L. Royer</b>  |  |  | 22d. PHYSICIAN'S NAME (Type)<br><b>DR. EARL L. Royer</b>   |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  |  | 22c. DATE SIGNED<br><b>1-25-69</b>   |  |  |  |  |                                |  |
| 22e. ADDRESS<br><b>Camden, Ave. Salisbury, Maryland.</b>  |  |  |  |  |  |   |  |  |  |  |  |  |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>1/28/69</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Nat. Cem.</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                  |  |  |  |  |                                |  |
| 24. FUNERAL DIRECTOR<br><b>Mitchell-Wiedefeld Home</b>  |  |  | ADDRESS<br><b>6500 York Rd.</b>  |  |  | 25a. BY REGISTRAR<br><b>JAN 28 1969</b>   |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |                                |  |
| DATE  |  |  |  |  |  |   |  |  |  |  |  |  |  |                                |  |

VR 13b (4)  
45Ms 1-69



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                              |  |   |  |                                     |  |  |     |
|---|------------------------------|--|---|--|-------------------------------------|--|--|-----|
| 01722   |                              | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |   |  |                                     | 01722  |  |     |
| 1. DECEASED-NAME<br>(Type or print)   |                              | First  | Middle  | Lost   | 2a. DATE OF DEATH<br>Month Day Year |  | 2b. HOUR<br>M                                |     |
| ALICE Louise MCCORMICK  |                              |  |   |  | JANUARY 7 1969                      |  | 6 45 P                                       |     |
| 3. SEX  | 4. RACE                      |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)     |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN     |     |
| Female  | White                        |  | March 3, 1906   |  | 62 YRS.                             |  |  |     |
| 7a. BIRTHPLACE (State or foreign country)   | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH                  |  |  | Md. |
| N.C.  | USA                          |  |   |  | Wicomico                            |  |  |     |
| 10. CITY OR TOWN OF DEATH   |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)                                       |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |                                     | 12b. KIND OF BUSINESS OR INDUSTRY  |  |     |
| Salisbury   |                              | Peninsula General Hospital   |   | Hospital Attend.   |                                     | Hospital   |  |     |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |                              | 13b. COUNTY  |   | 13c. CITY OR TOWN  |                                     | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |     |
| Md.   |                              | Wicomico   |   | Salisbury  |                                     | 1722 N. Salisbury Blvd.  |  |     |
| 14. FATHER'S NAME   |                              | 15. MOTHER'S MAIDEN NAME   |   | Address  |                                     |  |  |     |
| First Middle Last   |                              | First Middle Last  |   | Box 181  |                                     |  |  |     |
| John Willis   |                              | Effie Styron   |   |  |                                     |  |  |     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)   |                              | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |                                     |  |  |     |
| No  |                              |  |   | Mrs. Roxie Howland Empire, La.   |                                     |  |  |     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute effusion &amp; heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Carcinoma of lung</u> |                              |  |   |  |                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                              |  |   |  |                                     |  |  |     |
| 19a. DATE OF OPERATION  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |                                     | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |     |
| 1/7/69  |                              | Acute effusion   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                    |                                     |  |  |     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |                              | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)        |                                     |  |  |     |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                       |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                           |                                     |  |  |     |
|   |                              |  |   |  |                                     |  |  |     |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |                              |  |   |  |                                     |  |  |     |
| 22b. SIGNATURE  |                              | 22c. DATE SIGNED   |   | 22d. PHYSICIAN'S NAME (Type)   |                                     |  |  |     |
| Richard E. Hughes   |                              | 1/10/69  |   | 22e. ADDRESS   |                                     |  |  |     |
|   |                              |  |   |  |                                     |  |  |     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                              | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                     | 23d. LOCATION (City or Town) (County) (State)  |  |     |
| Burial  |                              | 1-12-1969  |   | Bethel Cemetery  |                                     | Chesapeake City, Cecil, Md.  |  |     |
| 24. FUNERAL DIRECTOR  |                              | ADDRESS  |   | 25a. REC'D BY REGISTRAR  |                                     | 25b. REGISTRAR'S SIGNATURE   |  |     |
| Thomas F. Wallace   |                              | Salisbury, Md.   |   | JAN 13 1969  |                                     | [Signature]  |  |     |

*[Faint, illegible markings]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |  |   |  |   |   |  |  |
|---|--|--|--|---|--|---|---|--|--|
| 01730   |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |   |  | 01723   |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  |  |   |  | 2a. DATE OF DEATH   |   | 2b. HOUR                                 |  |
| First Middle Last<br>Earl Morris  |  |  |  |   |  | Month Day Year<br>JANUARY 7 1969  |   | 7:45 AM                                  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>Nov. 8 1891   |  | 6. AGE (In years<br>lost birthday)<br>77 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>WICOMICO Md.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>SALISBURY  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>PENINSULA GENERAL HOSPITAL      |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired)<br>RETIRED POST MASTER  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>MARYLAND  |  | 13b. COUNTY<br>SOMERSET  |  | 13c. CITY OR TOWN<br>PRINCESS ANNE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER                   |  |
| 14. FATHER'S NAME First Middle Last<br>JOHN W. MORRIS   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>CLARA COLONNA   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)  |  | 17. INFORMANT<br>Address<br>COL. JOHN MORRIS PRINCESS ANNE, MD.   |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u><br>450 X DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 day  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                    |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-6, 1969, to 1-7, 1969, that (I) (we) last<br>saw the deceased alive on 1-7, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br>Wilbur R. Ellis   |  |  |  |   | DEGREE ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br>1-7-69  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>Wilbur R. Ellis  |  |  |  |   | 22e. ADDRESS   |   |   |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL  |  | 23b. DATE<br>1/10/1969   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MANOKIN PRES. CEMETERY  |  | 23d. LOCATION (City or Town) (County) (State)<br>PRINCESS ANNE, MD.                             |   |  |  |
| 24. FUNERAL DIRECTOR<br>LEVIN R. WILSON   |  |  |  |   | ADDRESS<br>PRINCESS ANNE, MD.  |   | 25a. REC'D BY REGISTRAR<br>DATE JAN 10 1969                             |  | 25b. REGISTRAR'S SIGNATURE<br>J. J. J. |

01123

U.S. DEPT. OF JUSTICE

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U.S. DEPT. OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |   |   |  |  |  |  |
|---|--|---|---|---|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |   |  |  |  |  |
| CERTIFICATE OF DEATH  |  |   |   |   |   |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>MARY</b>   |  |   | First <b>S.</b> Middle <b>MORRIS</b> Last                                     |   |   | 2a. DATE OF DEATH<br>Month <b>January</b> Day <b>8</b> Year <b>1969</b>              |  | 2b. HOUR<br><b>11:20A</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br><b>November 7, 1882</b>   |   | 6. AGE (In years last birthday)<br><b>86</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN <b></b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Caroline County</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>WICOMICO</b> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Deer's Head State Hospital</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housework</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                                     |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Caroline</b>   |   | 13c. CITY OR TOWN<br><b>Federalsburg</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |
| 14. FATHER'S NAME<br>First <b>George</b> Middle <b></b> Last <b>Smith</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Ida</b> Middle <b></b> Last <b>Dukes</b> |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-01-8052</b>  |   | 17. INFORMANT<br><b>Mrs. Addie Broadbent, Wilmington, Delaware</b> Address <b>442 South Bancroft PKWY</b>   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>450 X</b> IMMEDIATE CAUSE (a) <b>Pulmonary embolus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>   |  |   |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b>            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Cerebral vascular accident</b>  |  |   |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 25, 1968</b> , to <b>January 8, 1969</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 8, 1969</b> , and that in <b>(XX)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>L. V. Maldve, M. D.</b>  |  |   |   |   | DEGREE<br><b></b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/8/69</b>                                    |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>L. V. Maldve, M. D.</b>  |  |   |   |   | 22e. ADDRESS<br><b>Deer's Head State Hospital, Salisbury, Maryland</b>  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>January 11, 1969</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hill Crest</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Federalsburg Maryland</b>        |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Jerome Frampton Jr.</b><br><b>Frampton Funeral Home, Federalsburg, Md.</b>   |  |   |   |   | 25a. REC'D BY REGISTRAR<br><b>JA 13 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |   |   |  |  |     |
|--|--|--|--|---|---|---|--|--|-----|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |   |   |  |  |     |
| 01732 CERTIFICATE OF DEATH 01725   |  |  |  |   |   |   |  |  |     |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>Purnell Morton</b>   |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>January 17 1969</b>      |   |   | 2b. HOUR<br><b>4:10</b> M   |  |  |     |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>Negro</b>  |  | 5. DATE OF BIRTH<br><b>2/19/1968</b>  |   | 6. AGE (In years lost birthday)<br>YRS. MONTHS DAYS<br><b>11</b>                                |  | IF UNDER 1 YEAR<br>IF UNDER 24 HRS<br>HOURS MIN  |     |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Wicomico</b>   |  |  | Md. |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Peninsula General</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>None</b>  |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>                     |  |     |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Wicomico</b>   |  | 13c. CITY OR TOWN<br><b>Salisbury</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>11 Nokomis Ave.</b> |     |
| 14. FATHER'S NAME First Middle Last<br><b>Purnell Morton</b>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Yvonne Conway</b> |   |   |   |  |  |     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown (If yes give war or dates of service)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address<br><b>Purnell Morton Nokomis Ave. Salis. Md</b>   |   |   |  |  |     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br><b>471 X</b> DUE TO, OR AS A CONSEQUENCE OF <b>7 lu</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b><br><b>72 "</b> |  |  |  |   |   |   |  |  |     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |   |  |  |     |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |     |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |     |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State              |   |  |  |     |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/15</b> , 19 <b>69</b> , to <b>1/17</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1-17</b> 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |  |  |     |
| 22b. SIGNATURE<br><b>W. B. Smith</b>   |  |  |  |   | 22c. DATE SIGNED<br><b>1/22/69</b>  |   | 22d. PHYSICIAN'S NAME (Type)<br><b>W. B. Smith</b>                   |  |     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/21/69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Acres Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Salisbury Wicomico Md.</b>                  |  | 23e. AND REGISTERED<br><b>JAN 23 1969</b>        |     |
| 24. FUNERAL DIRECTOR<br><b>Clinton F. Stewart</b>  |  |  |  |   | ADDRESS<br><b>Salis. Md</b>   |   | 25. REGISTRAR<br><b>W. B. Smith</b>                                  |  |     |

01710

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JAN 2 1950  
LIBRARY OF THE  
UNITED STATES DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01733

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01726

|  |                  |   |                     |   |   |   |  |   |
|--|------------------|---|---------------------|---|---|---|--|---|
| 1. DECEASED-NAME<br>(Type or Print)  |                  | First<br>DORA   | Middle<br>VANDALIER | Last<br>NICKERSON   | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input type="checkbox"/> 1/3 1969 |   | 2b. HOUR<br>M  |   |
| 3. SEX<br>Female   | 4. RACE<br>White | 5. DATE OF BIRTH<br>July 27, 1897   |                     | 6. AGE (In years<br>last birthday)<br>71 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN.  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br>January 3 1969 | 2d. HOUR<br>M   |
| 7a. BIRTHPLACE (State or foreign<br>country) Virginia  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>WICOMICO  |  | Md.   |
| 10. CITY OR TOWN OF DEATH<br>Salisbury   |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Peninsula General Hospital |                     | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Retired Seamstress  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Shirt Factory   |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE Maryland  |                  | 13b. COUNTY Wicomico  |                     | 13c. CITY OR TOWN<br>Salisbury  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>535 Wailes Street             |
| 14. FATHER'S NAME<br>First Middle Last<br>Gordon Handy Nickerson   |                  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Dora Bradford  |                     | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br>No   |   |   |  |   |
| 16b. SOCIAL SECURITY NO.<br>213-14-1926 A  |                  | 17. INFORMANT (Son)<br>ADDRESS 535 Wailes St.<br>Mr. Albert H. Nickerson, Salisbury, Maryland                 |                     |   |   |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest with cerebral edema</u><br>887 X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. (b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                  |   |                     |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Multiple fractures.  |                  |   |                     |   |   |   |  |   |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |                     |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |   |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/><br>CAUSE OF DEATH  |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOURS MIN.<br>3:30 P.M. 12-17-68                                      |                     | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Fell at home.  |   |   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK  |                  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)<br>own home                   |                     | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>535 Wailes St., Salisbury, Wic., Md.  |   |   |  |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                  |   |                     |   |   |   |  |   |
| ACTUAL<br>SIGNATURE<br>EXAMINER'S<br>NAME (Type)   |                  | Earl L. Royer, M.D.<br>409 Camden Ave., Salisbury, Md.  |                     |   |   |   |  |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |                  | 23b. DATE<br>Jan. 6, 1969   |                     | 23c. NAME OF CEMETERY OR CREMATORY<br>Wicomico Memorial Park  |   | 23d. LOCATION (City or Town) (County) (State)<br>Salisbury, Wicomico, Maryland                  |  |   |
| 24. FUNERAL DIRECTOR<br>HOLLOWAY & COMPANY, SALISBURY, MARYLAND  |                  | 25a. REC'D BY REGISTRAR<br>JAN 8 1969   |                     | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |   |   |  |   |

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| No. |  | Date |  | Locality |  | Collector |  | Plant |  | Fruit |  | Seed |  | Notes |  |
|-----|--|------|--|----------|--|-----------|--|-------|--|-------|--|------|--|-------|--|
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PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |   |   |   |  |   |  |
|--|--|--|---|---|---|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |   |   |   |  |   |  |
| 01732  |  |  |   |   |   |   |  |   |  |
| Items #6,5,23,b,c,&d Film 409 1/200  |  |  |   |   |   |   |  |   |  |
| 01727  |  |  |   |   |   |   |  |   |  |
| CERTIFICATE OF DEATH   |  |  |   |   |   |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) <b>SHERMAN HARRISON</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>25</b> Year <b>69</b>                        |   |   | 2b. HOUR<br><b>4 30</b> M   |  |   |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>March 27, 1890</b>   |   | 6. AGE (In years last birthday)<br><b>78</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>YRS.</b>              |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Wicomico</b>   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>P.B. Hospital</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired Sheriff</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Lawyer</b>  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>  |  | 13b. COUNTY<br><b>Wicomico</b>   |   | 13c. CITY OR TOWN<br><b>Delmar</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>415 E. Elizabeth St.</b> |  |
| 14. FATHER'S NAME<br>First <b>George</b> Middle <b>Oliphant</b> Last <b>Oliphant</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Margaret</b> Middle <b>Hastings</b> Last <b>Hastings</b> |   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, go to unknown (If yes give year or dates of service)<br><b>yes</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>22-03-1171</b>   |   | 17. INFORMANT<br><b>George H Oliphant</b>                                       |   | Address<br><b>Delmar, Md.</b>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>1621</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>unknown</b> |  |  |   |   |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                    |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                         |   |   | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State                 |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-18</b> , 19 <b>69</b> , to <b>1-25</b> , 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>1-25</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Wilber R. Ellis Jr.</b>   |  |  |   |   | 22c. DATE SIGNED<br><b>1-25-69</b>  |   | 22d. PHYSICIAN'S NAME (Type)<br><b>Wilber R. Ellis Jr.</b>           |   |  |
| 22e. ADDRESS<br><b>Medical Center Salisbury, Maryland</b>  |  |  |   |   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/27/69</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stephen's</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Delmar, Sussex, Delaware</b>                |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>William M. Murrell</b>  |  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 27 1969</b>                              |   | 25b. REGISTRAR'S SIGNATURE<br><b>William M. Murrell</b>              |   |  |

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DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |   |  |  |  |  |
|--|--|--|--|--|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |   |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First  | Middle   | Lost  | 2a. DATE OF DEATH  |  |  | 2b. HOUR   |
| JULIA MAE PETERSON   |  |  |  |  |   | Month 1 Day 8 Year 69  |  |  | 9:20 A M   |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (In years lost birthday)  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN |  |
| FEMALE   |  | NEGRO  |  | 10-09-1888   |   | 80 YRS.  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |  | Md.  |
| Wicomico   |  | USA  |  |  |   | Wicomico   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)       |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                          |
| Salisbury  |  |  | Peninsula General Hospital   |  |   | Domestic   |  |  | None   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER                                 |  |
| MARYLAND   |  |  | WICOMICO   |  | QUANTICO  |  |  |  |  |
| 14. FATHER'S NAME  |  |  | First  | Middle   | Lost  | 15. MOTHER'S MAIDEN NAME   |  |  | First Middle Lost  |
| Benjamin   |  |  |  | Peters   |   | Julia Price  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  |  | Address  |  |
| No   |  |  |  |  | Peter Peterson  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4339 cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>hrs<br>yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus  |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
|  |  |  |  |  |   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |
|  |  |  |  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |
|  |  |  |  |  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-6, 1968, to 1-9, 1969, that (I) (we) last saw the deceased alive on 1-9, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE John S. Bulkeley M.D. REGREE  |  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  | 22e. ADDRESS  |  |  |  |  |
|  |  |  |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |
| Burial   |  | 1-13-69  |  | Green Acres Men.   |   | Salisbury Cecil MD   |  |  |  |
| 24. FUNERAL DIRECTOR Beader M. West  |  |  |  |  | 25a. REC'D BY REGISTRAR JAN 16 1969 DATE  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |                                |   |   |  |  |  |  |
|---|--|--|--|---|--------------------------------|---|---|--|--|--|--|
| 01736   |  | CERTIFICATE OF DEATH   |  |   |                                |   |   | 01729  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |   |                                | 2a. DATE OF DEATH<br>Month Day Year   |   |  | 2b. HOUR<br>4 AM                               |  |  |
| ELIZABETH   |  |  | ELLISON  |   |                                | PHIPPIN   |   |  | January 5 1969                                 |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>June 12, 1912   |                                |   | 6. AGE (In years last birthday)<br>56 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                 |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                |   | 9. COUNTY OF DEATH<br>WICOMICO Md.  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Peninsula General Hospital |   |                                | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Checker                  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Laundry   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  |  | 13b. COUNTY<br>Wicomico  |   | 13c. CITY OR TOWN<br>Salisbury |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>613 E. Church Street |  |  |
| 14. FATHER'S NAME<br>Harry V. Welch   |  |  | 15. MOTHER'S MAIDEN NAME<br>Bertha Ellison   |   |                                |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) (If yes give war or dates of service)<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>217-10-3826  |   |                                | 17. INFORMANT<br>Mr. Dallas R. Welch (Brother), Erie, Pa.<br>Mr. S. Brian Phippin (Son), Baltimore, Md.             |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Myocardial infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF <i>&amp; congestive heart failure</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |  |   |                                |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |   |                                | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)                                     |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   |                                | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>Nov 15 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |                                |   |   |  |  |  |  |
| 22b. SIGNATURE<br><i>Dr. E. M. Beardsley</i>  |  |  |  |   |                                | DEGREE<br>ATTENDING PHYS.<br>MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br>January 6 1969                                   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |  |  |   |                                | 23b. DATE<br>Jan. 8, 1969   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Parsons Cemetery               |  |  |  |
| 24. FUNERAL DIRECTOR<br>HOLLOWAY & COMPANY, SALISBURY, MARYLAND   |  |  |  |   |                                | 25a. REC'D BY REGISTRAR<br>JAN 10 1969  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                   |  |  |  |
| 23d. LOCATION (City or Town) (County) (State)<br>Salisbury, Wicomico, Maryland  |  |  |  |   |                                |   |   |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |                                   |  |  |  |                             |  |  |  |       |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|-----------------------------------|--|--|--|-----------------------------|--|--|--|-------|--|--|--|
| 01737   |  |  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                     |  |  |  |                                   |  |  |  |                             |  |  |  | 01730 |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Cleo M. Pusey   |  |  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH Month Day Year<br>January 11 1969   |  |  |  |                                   |  |  |  | 2b. HOUR<br>1:55 PM         |  |  |  |       |  |  |  |
| 3. SEX<br>Female  |  |  |  | 4. RACE<br>white   |  |  |  | 5. DATE OF BIRTH<br>AUG. 10, 1897  |  |  |  | 6. AGE (In years last birthday)<br>71 YRS.  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS       |  |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |       |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>ASHLAND, OHIO  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH<br>Wicomico Md.  |  |  |  |                                   |  |  |  |                             |  |  |  |       |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Peninsula General Hospital |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>NONE |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |                             |  |  |  |       |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MARYLAND   |  |  |  | 13b. COUNTY<br>SOMERSET  |  |  |  | 13c. CITY OR TOWN<br>PRINCESS ANNE   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |  |  |  | 13e. STREET AND NUMBER            |  |  |  |                             |  |  |  |       |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>CHARLES RICHARDS   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>EMMA EWING |  |  |  |  |  |   |  |  |  |                                   |  |  |  |                             |  |  |  |       |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  | 17. INFORMANT Address<br>MRS. PAUL WINDSOR PRINCESS ANNE, MD.  |  |  |  |   |  |  |  |                                   |  |  |  |                             |  |  |  |       |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>5330 IMMEDIATE CAUSE (a) <u>Pertussis &amp; associated pulmonary embolism</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>embolism</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>perforated peptic ulcer</u><br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 DAYS  |  |  |  |                                   |  |  |  |                             |  |  |  |       |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Chronic obstructive pulmonary disease</u>  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |                                   |  |  |  |                             |  |  |  |       |  |  |  |
| 19a. DATE OF OPERATION<br>1/9/69  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Repaired peptic ulcer</u>                           |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |                                   |  |  |  |                             |  |  |  |       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |  |  |  |                                   |  |  |  |                             |  |  |  |       |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work   |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |   |  |  |  |                                   |  |  |  |                             |  |  |  |       |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>1-11-69</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>1-11-69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.   |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |                                   |  |  |  |                             |  |  |  |       |  |  |  |
| 22b. SIGNATURE<br><u>Levin R. Wilson</u>  |  |  |  | 22c. DATE SIGNED<br>1-13-69  |  |  |  | 22d. PHYSICIAN'S NAME (Type)<br>LEVIN R. WILSON  |  |  |  | 22e. ADDRESS<br>PRINCESS ANNE, MD.  |  |  |  |                                   |  |  |  |                             |  |  |  |       |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |  |  |  | 23b. DATE<br>1/14/1969   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ST. ANDREW CEMETERY  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>PRINCESS ANNE, MD.                             |  |  |  |                                   |  |  |  |                             |  |  |  |       |  |  |  |
| 24. FUNERAL DIRECTOR<br>LEVIN R. WILSON   |  |  |  | 25. REF. BY REGISTRAR<br>JAN 15 1969   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |  |  | 25c. DATE   |  |  |  |                                   |  |  |  |                             |  |  |  |       |  |  |  |

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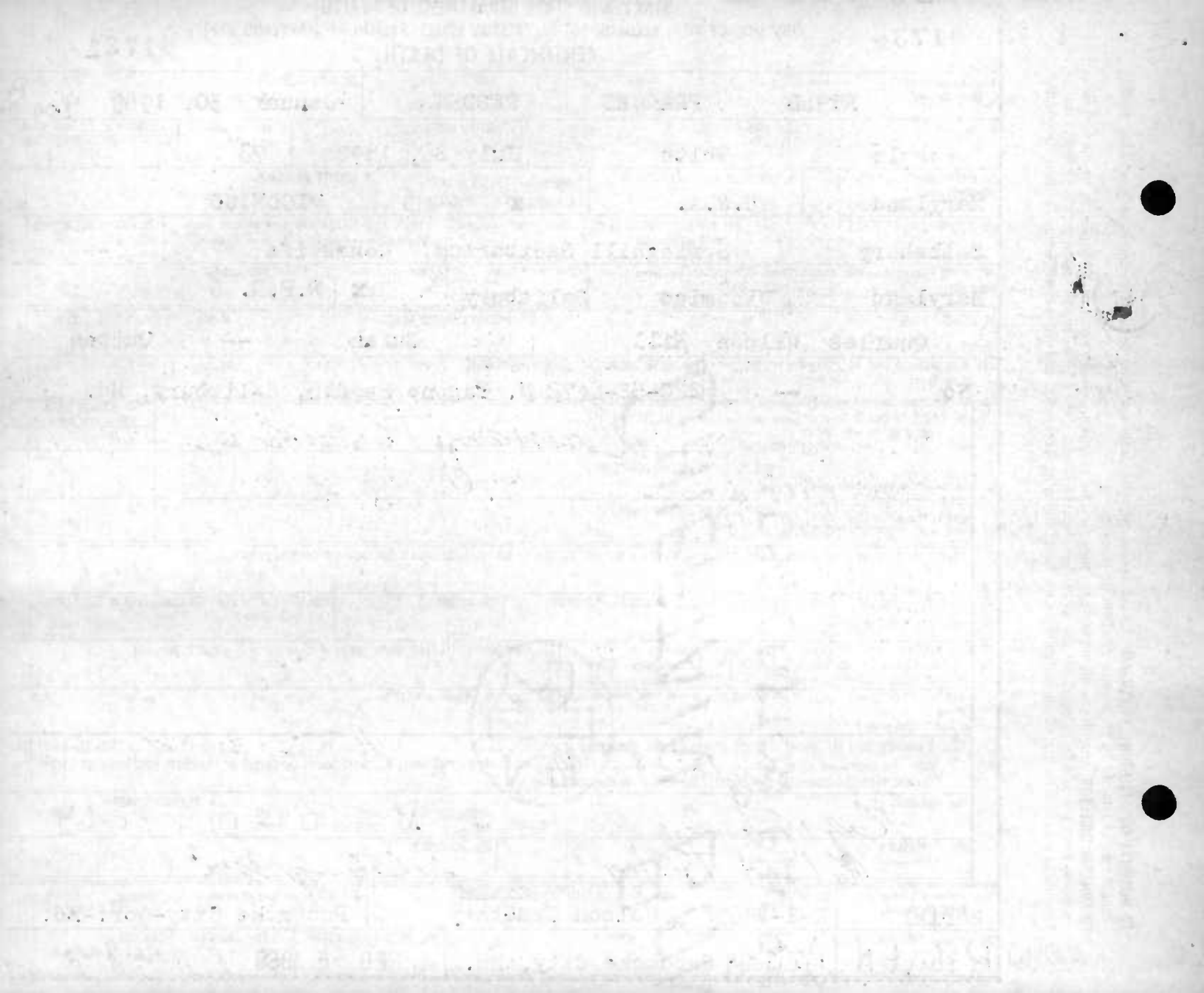
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |  |  |                                |  |
|---|--|--|--|---|--|--|--|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |  |                                |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |                                |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  |  |   | 2a. DATE OF DEATH  |  |  | 2b. HOUR                       |  |
| First Middle Last<br>ETHEL FRANCES REDDEN   |  |  |  |   | January 30, 1969   |  |  | 9:00 P.M.                      |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS |  |
| Female  |  | White  |  | July 28, 1890   |  | 78 YRS.  |  |                                |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |                                | Md.  |
| Maryland  |  | U.S.A.   |  |   |  | WICOMICO   |  |                                |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                                |  |
| Salisbury   |  | Springhill Sanitarium  |  | Housewife   |  | --   |  |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER         |  |
| Maryland  |  | Wicomico   |  | Salisbury   |  |  |  | R.F.D. 6                       |  |
| 14. FATHER'S NAME First Middle Last   |  |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last   |  |  |                                |  |
| Charles Wilson Hill   |  |  |  |   | Eurah -- Outten  |  |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address   |  |  |  |                                |  |
| No  |  | 220-52-8672  |  | N. Eugene Redden, Salisbury, Md.  |  |  |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cornary Thrombosis</u><br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |  |  |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)  |  |  |  |   |  |  |  |                                |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |  |                                |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town   |  | County State                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1948 to 12-30, 1969, that (I) (we) last saw the deceased alive on 12-28 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |                                |  |
| 22b. SIGNATURE <u>R. H. Wilson</u>  |  |  |  |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED 1-31-69   |                                |  |
| 22d. PHYSICIAN'S NAME (Type) <u>R. H. Wilson</u>  |  |  |  |   | 22e. ADDRESS <u>Salisbury, Md.</u>   |  |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORIUM  |  | 23d. LOCATION (City or Town) (County) (State)  |  |                                |  |
| Burial  |  | 2-2-1969   |  | Nelson Cemetery   |  | Pocomoke City-Wor.-Md.   |  |                                |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  |   | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |                                |  |
| Robert H. Wilson Pocomoke City, Md.   |  |  |  |   | DATE FEB 5 1969  |  | <u>Charles Judge</u>   |                                |  |





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01739

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01732

|  |              |  |   |   |                                |  |  |
|--|--------------|--|---|---|--------------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or Print) First Middle Last<br>H. CLIFFORD RIALI   |              |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year<br>1-4-69 19 |   |                                | 2b. HOUR<br>12:30 M  |  |
| 3. SEX<br>M  | 4. RACE<br>W | 5. DATE OF BIRTH<br>2-23-02  | 6. AGE (In years last birthday)<br>66 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br>Month 1 Day 4 Year 1969                                  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Md.   |              | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. COUNTY OF DEATH<br>Wicomico   |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury   |              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>313 Middle Blvd. |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Farmer   |                                | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Farm  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   |              | 13b. COUNTY<br>Wicomico  |   | 13c. CITY OR TOWN<br>Tyaskin  |                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER   |              | 14. FATHER'S NAME First Middle Last<br>J. Hiliary Riall  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Ella Parks  |                                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No  |              | 16b. SOCIAL SECURITY NO.<br>(If yes give number or dates of service)                             |   | 17. INFORMANT<br>Pauline Riall  |                                | ADDRESS<br>5315 Gary, Md.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u><br>481X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |              |  |   |   |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>days                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |              |  |   |   |                                |  |  |
| 19a. DATE OF OPERATION   |              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |                                | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |              | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br>19                                     |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                     |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |              |  |   |   |                                |  |  |
| ACTUAL SIGNATURE<br>Earl L. Royer, M.D.  |              | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |                                | 22b. DATE SIGNED<br>Jan. 6, 1969   |  |
| EXAMINER'S NAME (Type)<br>409 Camden Ave., Salisbury, Md.  |              | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                      |   | ADDRESS (Street, city, town, or county)   |                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>burial  |              | 23b. DATE<br>1-7-69  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Mary's  |                                | 23d. LOCATION (City or Town) (County) (State)<br>Tyaskin, Wicomico, Md.              |  |
| 24. FUNERAL DIRECTOR<br>Messick Funeral Home, Bivalve, Md.   |              |  |   | 25a. REC'D BY REGISTRAR<br>DATE JAN 10 1969   |                                | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 01740  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                          |  |   |  | 01733  |  |
| Item#5, FilmG409 2/3/69 km   |  |  |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>Hattie J. ROLEY   |  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br>JANUARY 22 1969  |  | 2b. HOUR<br>7:28 P.M.  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Negro   |  | 5. DATE OF BIRTH<br>Dec. 2 1890   |  | 6. AGE (In years, months, days)<br>78 yrs. 11 mos. 20 days   |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Wicomico Md.   |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Peninsula Gen. Hosp. |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Domestic   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Housewife   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   |  | 13b. COUNTY<br>Worcester   |  | 13c. CITY OR TOWN<br>Pocomoke   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>13e. STREET AND NUMBER<br>R.F.D. 2 Bx. 215 |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Caleb Dickerson  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Henrietta Schoolfield                               |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>213-24-26708   |  | 17. INFORMANT<br>Otha James   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pulmonary Embolism<br>402X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) Congestive Heart Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Hyper-tensive Heart Disease<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>15 mins.<br>2 weeks<br>Not Known |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Anemia, Anemia -   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                         |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/20/1969, to 1/22/1969, that (I) (we) last saw the deceased alive on 1/22/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>[Signature]  |  |  |  | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  | 22e. ADDRESS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>1-27-69   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Trinity Meth. Cem.  |  | 23d. LOCATION (City or Town) (County) (State)<br>Pocomoke Wor. Md.   |  |
| 24. FUNERAL DIRECTOR<br>[Signature]  |  |  |  | 25a. REC'D BY REGISTRAR<br>JAN 28 1969  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <span>01741</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>01734</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>  |  |   |  |   |   |  |   |   |  |   |  |
|---|--|---|--|---|---|--|---|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>EMILY WILT SCHWEPPE</b>  |  |   |  |   |   | 2a. DATE OF DEATH<br>Month <b>1</b> Day <b>3</b> Year <b>1969</b>  |   |   | 2b. HOUR<br><b>M</b>                                 |   |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br><b>4/21/1877</b>  |   | 6. AGE (In years last birthday)<br><b>91</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                          |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN <b></b>               |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Ohio</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Wicomico</b> Md.  |   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Springhill Pr. Sanatorium</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>housewife</b>                    |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b> |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Wicomico</b>   |   | 13c. CITY OR TOWN<br><b>Salisbury</b>                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>Camden Ave. ext.</b>    |   |  |
| 14. FATHER'S NAME<br>First <b>Abram</b> Middle <b>Wilt</b> Last <b></b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Ella</b> Middle <b>Bickham</b> Last <b></b>                                 |   |   |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown) <b>no</b> (If yes give war or dates of service)  |  |   | 16b. SOCIAL SECURITY NO.<br><b></b>  |   | 17. INFORMANT<br>Address <b>E. Dale Adkins, Jr. see sec. # 13</b> |  |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4339 circulatory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>generalized arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>yes.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>prev. cerebral thromboses</b>  |  |   |  |   |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?    |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. <b></b> Month <b></b> Day <b></b> Year <b>19</b><br>P.M. <b></b> |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                      |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 1968</b> to <b>1/3 1969</b> , that (I) (we) last saw the deceased alive on <b>1/3 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Earl M. Beardsley</b>  |  |   |  |   |   | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/4/69</b>                                       |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>EARL M. BEARDSLEY, M.D.</b>  |  |   |  |   |   | 22e. ADDRESS<br><b>211 Maryland Ave. Salisbury, Md. 21801</b>  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>   |  | 23b. DATE<br><b>1/4/1969</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>J.Wm. Lee &amp; Sons</b>   |   |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Washington D.C.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Hill Funeral Home Salisbury, Md. 21801</b>   |  |   |  | ADDRESS<br><b></b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 8 1969</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Richard Judge</b>                      |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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01742

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

01735

|   |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>John Calvin Scott</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>5</b> Year <b>1969</b> |   |  | 2b. HOUR P.<br><b>7:00 M</b>  |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>June 3, 1890</b>   |  | 6. AGE (In years last birthday)<br><b>78 YRS.</b>                         |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Wicomico</b>                                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Deer's Head State Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>grocery store merchant</b>                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived/admission) STATE<br><b>Maryland</b>  |  | 13b. CITY OR TOWN<br><b>Caroline</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>RFD #1, Box 533, Liberty Rd.</b>             |  |  |  |
| 14. FATHER'S NAME<br>First <b>John B.</b> Middle <b>Scott</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Ida</b> Middle <b>Nichols</b>   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219-07-3880</b>  |  | 17. INFORMANT<br>Address <b>C. Theodore Scott Federalsburg, Md.</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>485X</b> IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b> |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Coronary arteriosclerosis, severe</b>  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) ( <del>we</del> ) attended the deceased from <b>6/3</b> , 19 <b>68</b> , to <b>1/5</b> , 19 <b>69</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>1/5</b> , 19 <b>69</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.                       |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>C. H. Winnacott, M. D.</b>   |  |   |  | 22c. DATE SIGNED<br><b>1/6/69</b>   |  | 22d. PHYSICIAN'S NAME (Type)<br><b>C. H. Winnacott, M. D.</b>             |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Buried</b>  |  | 23b. DATE<br><b>1/8/69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Federalsburg Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Federalsburg, Md.</b> |  | 23e. REC'D BY REGISTRAR<br><b>JAN 9 1969</b>                     |  |
| 24. FUNERAL DIRECTOR<br><b>Charles J. ...</b>   |  | ADDRESS<br><b>Federalsburg, Md.</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. ...</b>   |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |                          |   |  |  |  |
|---|--|---|--|---|--------------------------|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |                          |   |  |  |  |
| CERTIFICATE OF DEATH  |  |   |  |   |                          |   |  |  |  |
| 1. DECEASED-NAME (Type or print)  |  |   |  |   | 2a. DATE OF DEATH        |   |  | 2b. HOUR   |  |
| First Middle Last<br>Mary E. Shanton  |  |   |  |   | Month Day Year<br>1 6 69 |   |  | 9 <sup>10</sup> AM   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Cauc.  |  | 5. DATE OF BIRTH<br>3-9-88  |                          | 6. AGE (In years lost birthday)<br>80 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Balto. Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. COUNTY OF DEATH<br>Wicomico Co. Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Wicomico Nursing Home |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>RETIRED  |                          | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOUSEHOLD  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |  | 13b. COUNTY<br>Somerset   |  | 13c. CITY OR TOWN<br>Chance   |                          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |
| 14. FATHER'S NAME First Middle Last<br>ROBERT H. DOUGHERTY  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>MARY B.V. SENER   |  |   |                          |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>UNKNOWN   |  | 17. INFORMANT Address<br>Mrs. HELEN PAYNE - CHANCE MD 21816   |                          |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>VIRUS PNEUMONIA</u><br>471X DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Influenza</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><u>Arteriosclerosis</u> |  |   |  |   |                          |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                          | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                          |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                          |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 10, 1969, to 1-6, 1969, that (I) (we) last saw the deceased alive on 1-5, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |                          |   |  |  |  |
| 22b. SIGNATURE<br>Leroy Webster   |  |   |  | DEGREE<br>ATTENDING PHYS.   |                          | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>          |  | 22c. DATE SIGNED<br>1-8-69                                       |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Leroy Webster   |  |   |  | 22e. ADDRESS<br>Salisbury, Md.  |                          |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |  | 23b. DATE<br>1-8-1969   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BEECHWOOD CEMETERY  |                          | 23d. LOCATION (City or Town) (County) (State)<br>PRINCESS ANNE Som MD                           |  |  |  |
| 24. FUNERAL DIRECTOR<br>Leroy Webster   |  | ADDRESS<br>Princess Anne  |  | 25a. REC'D BY REGISTRAR<br>DATE<br>JAN 14 1969  |                          | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |  |  |

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| 01742   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 01737  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  |  |  |  |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| CLARA   |  |  |  |  |  |  |  |  |  | VERONICA   |  |  |  |  |  |  |  |  |  | SIGLER   |  |  |  |  |  |  |  |  |  | Month Day Year   |  |  |  |  |  |  |  |  |  | January 18 1969        |  |  |  |  |  |  |  |  |  | M                |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  |  |  |  |  |  |  |  |  | 4. RACE  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday)                                      |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR        |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| Female  |  |  |  |  |  |  |  |  |  | White  |  |  |  |  |  |  |  |  |  | March 27, 1893   |  |  |  |  |  |  |  |  |  | 75   |  |  |  |  |  |  |  |  |  | MONTHS                 |  |  |  |  |  |  |  |  |  | DAYS             |  |  |  |  |  |  |  |  |  | HOURS |  |  |  |  |  |  |  |  |  | MIN |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |  |  |  |  |  | Md.                    |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| Maryland  |  |  |  |  |  |  |  |  |  | USA  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | WICOMICO   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| Salisbury   |  |  |  |  |  |  |  |  |  | Springhill Sanitarium  |  |  |  |  |  |  |  |  |  | Housewife  |  |  |  |  |  |  |  |  |  | ---  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |  |  |  |  |  |  |  | 13b. COUNTY  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?   |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| Maryland  |  |  |  |  |  |  |  |  |  | Wicomico   |  |  |  |  |  |  |  |  |  | Salisbury  |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>             |  |  |  |  |  |  |  |  |  | Getman Drive           |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  |  |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| James   |  |  |  |  |  |  |  |  |  | Dempsey  |  |  |  |  |  |  |  |  |  | Mary   |  |  |  |  |  |  |  |  |  | Broderick  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  |  |  |  |  |  | 17. INFORMANT  |  |  |  |  |  |  |  |  |  | Rt. 7 Address  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| No  |  |  |  |  |  |  |  |  |  | 218-01-3360D   |  |  |  |  |  |  |  |  |  | Mrs. Clara S. Livingood  |  |  |  |  |  |  |  |  |  | Salisbury, Maryland  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  | PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 4339  |  |  |  |  |  |  |  |  |  | IMMEDIATE CAUSE (a) Cerebral Thrombosis                                      |  |  |  |  |  |  |  |  |  | 2 days   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |  |  |  |  | (b)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | (c)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |  |  | generalized atherosclerosis  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY?  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | HOUR A.M. Month Day Year   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | P.M. 19  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  |  |  |  |  |  | 21f. LOCATION  |  |  |  |  |  |  |  |  |  | Street or R.F.D. No. City or Town County State                       |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 15, 1966, to 7/15, 1969, that (I) (we) last saw the deceased alive on June 15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| Dr. E. M. Beardsley   |  |  |  |  |  |  |  |  |  | January 17 / 1969  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| Dr. E. M. Beardsley   |  |  |  |  |  |  |  |  |  | 211 Maryland Ave., Salisbury, Maryland                                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |  |  |  |  |  |  |  | 23b. DATE  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)                        |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| Burial  |  |  |  |  |  |  |  |  |  | Jan. 20, 1969  |  |  |  |  |  |  |  |  |  | St. Peters Cemetery  |  |  |  |  |  |  |  |  |  | Westernport, Maryland  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |  |  |  |  | ADDRESS  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| HOLLOWAY & COMPANY, SALISBURY, MARYLAND   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | JAN 21 1969  |  |  |  |  |  |  |  |  |  | William J. Judge   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |

1917

CERTIFICATE OF DEATH

1917

DEPARTMENT OF HEALTH, CITY OF NEW YORK

Blank form with faint horizontal lines and ghosted text from the reverse side.

Vertical text on the right margin, likely a filing or processing stamp.

Vertical text on the far right margin, possibly a date or reference number.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (A)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |   |  |                                |   |
|---|--|--|--|---|--|---|--|--------------------------------|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |                                |   |
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |                                |   |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  | Middle  | Last   | 2a. DATE OF DEATH<br>Month Day Year   |  |                                | 2b. HOUR  |
| ELLE HUMPHREYS SIMMS  |  |  |  |   |  | 1 14 1969   |  |                                | 3:55 M  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS |   |
| Female  |  | White  |  | Aug. 31, 1910   |  | 38 YRS.   |  |                                |   |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                                | Md.   |
| Maryland  |  | U.S.A.   |  |   |  | Wicomico  |  |                                |   |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |                                | 12b. KIND OF BUSINESS OR INDUSTRY                       |
| Salisbury   |  |  | Peninsula General Hospital   |   |  | House wife  |  |                                | Own Home  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                | 13e. STREET AND NUMBER                                  |
| Maryland  |  |  | Wicomico   |   | Hebron   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |                                | Rt. #1  |
| 14. FATHER'S NAME   |  |  | First  | Middle  | Last   | 15. MOTHER'S MAIDEN NAME  |  |                                | First Middle Last                                       |
| Thomas  |  |  |  |   | Humphreys  | Sara  |  |                                | Margaret Holston  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)   |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address  |   |  |                                |   |
| No  |  |  | UNKNOWN  |   | Mr. William E. Simms, Sr. See sec 13   |   |  |                                |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>PERITONITIS 20 + PERFORATED</u><br>5621 DUE TO, OR AS A CONSEQUENCE OF <u>DIVERTICULUM SIGMOID COLON</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____ |  |  |  |   |  |   |  |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 DAYS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>RHEUMATOID ARTHRITIS</u>   |  |  |  |   |  |   |  |                                |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                |   |
| None  |  |  |  |   |  |   |  |                                |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |                                |   |
|   |  |  |  |   |  |   |  |                                |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County State                   |   |
|   |  |  |  |   |  |   |  |                                |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-8</u> , 1969, to <u>1-14</u> , 1969, that (I) (we) lost saw the deceased alive on <u>1-13</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                  |  |  |  |   |  |   |  |                                |   |
| 22b. SIGNATURE <u>Dr. W. E. Simms</u>   |  |  |  |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED <u>1-14-69</u>  |                                |   |
| 22d. PHYSICIAN'S NAME (Type) <u>Dr. Nevins W. Todd</u>  |  |  |  |   | 22e. ADDRESS <u>Medical Ctr. Salisbury, Md.</u>  |   |  |                                |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |  |                                |   |
| Burial  |  | 1-16-1969  |  | Wicomico Memorial Park  |  | Salisbury, Wicomico, Md.  |  |                                |   |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  |   | 25a. REC'D BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |                                |   |
| Hill Funeral Home Salisbury, Maryland   |  |  |  |   | JAN 17 1969  |   | <u>Charles Judge</u>   |                                |   |

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| 01746   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |  | 01739  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH   |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Robert Livigston Sterne III   |  |  |  |  |  |  |  |  |  | 1 Month 3 Day 1969  |  |  |  |  |  |  |  |  |  | 940p M   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 3. SEX Male   |  |  |  |  |  |  |  |  |  | 4. RACE White   |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH 1/2/1969  |  |  |  |  |  |  |  |  |  | 6. AGE (In years lost birthday) 0 YRS.   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) Maryland  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH Wicomico Md.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH Salisbury   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pen. Gen. Hosp.                                    |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Infant   |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland  |  |  |  |  |  |  |  |  |  | 13b. COUNTY Wicomico  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN Salisbury  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER 530D Alabama Ave. Camden Ave. ext.   |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last Robert Livingston Sterne, Jr.   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last Patricia K. Smith  |  |  |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. None  |  |  |  |  |  |  |  |  |  | 17. INFORMANT Address Mr. Robert L. Sterne, Jr. see sec #13 |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 777X Immaturity (1 lb 13 1/2 oz)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/2, 1969, to 1/3, 1969, that (I) (we) last saw the deceased alive on 1/3, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE D. S. Anderson, M.D. DEGREE  |  |  |  |  |  |  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED 1/4/69  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) Dr. D.G. Anderson  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS Medical Center, Salisbury, Maryland  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |  |  |  |  |  |  |  |  |  | 23b. DATE 1-7-1969  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY West Laurel Hills Cemetery Philadelphia, Pa.  |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR Hill Funeral Home Salisbury, Maryland  |  |  |  |  |  |  |  |  |  | ADDRESS   |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR JAN 8 1969   |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 11/69  
45M

| MARYLAND STATE DEPARTMENT OF HEALTH   |         |  |  |  |   |   |  |                                |   |
|---|---------|--|--|--|---|---|--|--------------------------------|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |  |  |  |   |   |  |                                |   |
| CERTIFICATE OF DEATH  |         |  |  |  |   |   |  |                                |   |
| 1. DECEASED-NAME<br>(Type or print)   |         |  | First Middle Last  |  |   | 2a. DATE OF DEATH<br>Month Day Year   |  |                                | 2b. HOUR  |
| ANTHONY SCOTT   |         |  | Trischler  |  |   | January 17 69   |  |                                | 1:52 M  |
| 3. SEX  | 4. RACE |  | 5. DATE OF BIRTH   |  |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS |   |
| Male  | White   |  | 1/12/69  |  |   | 2   |  | 0 5                            |   |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> Baby <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |                                |   |
| Maryland  |         | USA  |  |  |   | Wicomico Md.  |  |                                |   |
| 10. CITY OR TOWN OF DEATH   |         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |                                | 12b. KIND OF BUSINESS OR INDUSTRY   |
| Salisbury   |         |  | Peninsula General Hospital   |  |   | None  |  |                                | ---   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 13e. STREET AND NUMBER         |   |
| Maryland  |         |  | Wicomico   |  | Parsonsburg   |   |  | R.D. 2, Wainwright Ave.        |   |
| 14. FATHER'S NAME<br>First Middle Last  |         |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last                                |  |   |   |  |                                |   |
| William Charles Trischler   |         |  | Christi D. Ardis   |  |   |   |  |                                |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |         |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT (Father) R.D. 2 Address Wainwright Ave.   |   |  |                                |   |
| --  |         |  |  |  | Mr. William Charles Trischler, Parsonsburg, Md  |   |  |                                |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Isaemic Petechial Hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Perinatal Anoxia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Compression by head of prolapsed cord</u>  |         |  |  |  |   |   |  |                                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>5 days 2h 52m</u><br><u>5 days 2h 52m</u><br><u>5 days 2h 52m</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>None</u>  |         |  |  |  |   |   |  |                                |   |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?           |                                |   |
| <u>None</u>   |         | <u>None</u>  |  |  |   |   |  |                                |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |                                |   |
|   |         |  |  |  |   |   |  |                                |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |  |                                |   |
|   |         |  |  |  |   |   |  |                                |   |
| 22a. I certify that (N) (this hospital) attended the deceased from <u>1/12/69</u> , 19 <u>69</u> , to <u>1/17/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1/16/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |         |  |  |  |   |   |  |                                |   |
| 22b. SIGNATURE<br><u>Chester C. Collins MD</u>  |         |  |  |  | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><u>1/17/69</u>   |                                |   |
| 22d. PHYSICIAN'S NAME (Type)<br>Dr. Chester C. Collins  |         |  |  |  | 22e. ADDRESS<br>Salisbury, Maryland   |   |  |                                |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |         | 23b. DATE<br>Jan. 18, 1969   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Wicomico Memorial Park   |   |   | 23d. LOCATION (City or Town) (County) (State)<br>Salisbury, Wicomico, Maryland |                                |   |
| 24. FUNERAL DIRECTOR<br>HOLLOWAY & COMPANY, SALISBURY, MARYLAND   |         |  |  |  | 25a. REC'D BY REGISTRAR<br>JAN 21 1969  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                             |                                |   |

01350

CERTIFICATE OF DEATH

01350

Blank certificate form with horizontal lines for text entry.

JAN 1 1968

DEPARTMENT OF HEALTH AND HUMAN SERVICES



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiners Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

|  |  |                      |  |   |  |  |  |   |  |   |  |   |  |                       |  |
|--|--|----------------------|--|---|--|--|--|---|--|---|--|---|--|-----------------------|--|
| 1. DECEASED-NAME (Type or Print) <b>EDWIN KELSO TUBBS</b>  |  |                      |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>1</b> Day <b>31</b> Year <b>69</b> |  | 2b. HOUR <b>10:25</b>   |  |                       |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b> |  | 5. DATE OF BIRTH <b>5-31-05</b>   |  | 6. AGE (In years last birthday) <b>63</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN <b>0</b>   |  | 2c. DATE PRONOUNCED DEAD<br>Month <b>1</b> Day <b>31</b> Year <b>69</b>             |  | 2d. HOUR <b>10:25</b> |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. COUNTY OF DEATH <b>Wicomico</b>  |  |                       |  |
| 10. CITY OR TOWN OF DEATH <b>Salisbury</b>   |  |                      |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General</b> |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>carpenter</b>  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>   |  |                      |  | 13b. COUNTY <b>Wicomico</b>   |  |  |  | 13c. CITY OR TOWN <b>Willards</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 13e. STREET AND NUMBER <b>Route 1</b>   |  |                       |  |
| 14. FATHER'S NAME First <b>Elijah</b> Middle <b>Tubbs</b> Last <b>Tubbs</b>  |  |                      |  |   |  | 15. MOTHER'S MAIDEN NAME First <b>Margaret Ann</b> Middle <b>Truitt</b> Last <b>Truitt</b> |  |   |  |   |  |   |  |                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  |                      |  | 16b. SOCIAL SECURITY NO. <b>214-16-4498</b>   |  | 17. INFORMANT ADDRESS <b>Mrs. Edwin K. Tubbs, Willards, Md.</b>                            |  |   |  |   |  |   |  |                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic cardio-vascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                              |  |                      |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>sudden</b>                       |  |                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |  |                      |  |   |  |  |  |   |  |   |  |   |  |                       |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                       |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>19</b><br>P.M.                                   |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |   |  |   |  |                       |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                      |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                          |  |  |  | 21f. LOCATION Street or R.F.D. No. <b>Willards</b>  |  | City or Town <b>Willards</b>  |  | County <b>Wicomico</b>  |  | State <b>Md.</b>      |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                      |  |   |  |  |  |   |  |   |  |   |  |                       |  |
| ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>  |  |                      |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  | 22b. DATE SIGNED <b>Feb. 3, 1969</b>  |  |                       |  |
| EXAMINER'S NAME (Type) <b>409 Camden Ave., Salisbury, Md.</b>  |  |                      |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |  |  | ADDRESS (Street, city, town, or county)   |  |   |  |   |  |                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |                      |  | 23b. DATE <b>2-3-69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Truitt's Cemetery</b>                                |  |   |  | 23d. LOCATION (City or Town) <b>Willards</b> (County) <b>Wic.</b> (State) <b>Md.</b>                    |  |   |  |                       |  |
| 24. FUNERAL DIRECTOR ADDRESS <b>Hill Funeral Home, Salisbury, Md.</b>  |  |                      |  |   |  | 25a. REC'D BY REGISTRAR <b>FEB 5 1969</b>  |  |   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |   |  |                       |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15  
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |                          |   |  |  |  |                                |                   |
|--|--|--|--------------------------|---|--|--|--|--------------------------------|-------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |                          |   |  |  |  |                                |                   |
| CERTIFICATE OF DEATH   |  |  |                          |   |  |  |  |                                |                   |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First                    | Middle  | Last   | 2a. DATE OF DEATH  |  |                                | 2b. HOUR          |
| ETHEL  |  |  | CATHERINE                | WHITE   |  | January 6 1969   |  |                                | 5:20PM            |
| 3. SEX   |  | 4. RACE  |                          | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS |                   |
| Female   |  | White  |                          | Sept. 17, 1907  |  | 61 YRS.  |  | IF UNDER 24 HRS.<br>HOURS MIN  |                   |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  | Md.                            |                   |
| Maryland   |  | USA  |                          |   |  | WICOMICO   |  |                                |                   |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                                |                   |
| Salisbury  |  | Peninsula General Hospital   |                          | Seamstress  |  | Shirt Factory  |  |                                |                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER         |                   |
| Maryland   |  | Wicomico   |                          | Eden  |  |  |  | R.D. 2, Walnut Tree Road       |                   |
| 14. FATHER'S NAME  |  |  | First                    | Middle  | Last   | 15. MOTHER'S MAIDEN NAME   |  |                                | First Middle Last |
| Isaac  |  |  | Mills                    |   |  | Blanch   |  |                                | Bailey            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or (unknown) (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO. |   | 17. INFORMANT (Daughter)   |  | Address  |                                |                   |
| No   |  |  | 218-30-1730              |   | Mrs. June M. Wilkinson, Hebron, Maryland   |  | 111 Church St.   |                                |                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma - 2° to Bronchus.</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Angioma</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>174X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |                          |   |  |  |  |                                |                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |                          |   |  |  |  |                                |                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                |                   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |                                |                   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No.  |  | City or Town   |  | County State                   |                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-2</u> , 19 <u>65</u> , to <u>1-6</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>1-8</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |  |  |                          |   |  |  |  |                                |                   |
| 22b. SIGNATURE <u>Neve W. Todd, Jr.</u>  |  |  |                          |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED January 8 / 1969                                    |                                |                   |
| 22d. PHYSICIAN'S NAME (Type) Dr. Nevins W. Todd, Jr.   |  |  |                          |   | 22e. ADDRESS Medical Center, Salisbury, Maryland   |  |  |                                |                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |                                |                   |
| Burial   |  | Jan. 9, 1969   |                          | Siloam Cemetery   |  | Siloam, Wicomico, Maryland   |  |                                |                   |
| 24. FUNERAL DIRECTOR ADDRESS   |  |  |                          |   | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |                                |                   |
| HOLLOWAY & COMPANY, SALISBURY, MARYLAND  |  |  |                          |   | JAN 10 1969  |  | <u>Charles J. J...</u>   |                                |                   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |   |   |  |  |          |
|---|--|--|--|---|---|---|--|--|----------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |   |   |  |  |          |
| CERTIFICATE OF DEATH  |  |  |  |   |   |   |  |  |          |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  | Middle  | Last  | 2a. DATE OF DEATH<br>Month Day Year   |  |  | 2b. HOUR |
| None  |  |  | Susan  | Wilkinson   | January 20 1969   | 5:00 PM   |  |  |          |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |          |
| Female  |  | White  |  | Sept. 22, 1891  |   | 77 YRS.   |  |  |          |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |  |          |
| Virginia  |  | U.S.A.   |  |   |   | WICOMICO Md.  |  |  |          |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY            |          |
| Salisbury   |  |  | Peninsula Gen. Hosp.   |   |   | Housewife   |  | --   |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. CITY OR TOWN  |   | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                |   | 13e. STREET AND NUMBER   |  |          |
| Maryland  |  |  | Worcester  |   | Pocomoke  |   | 807 Fourth Street  |  |          |
| 14. FATHER'S NAME First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |   |   |   |  |  |          |
| Edward Thomas McCreedy  |  |  | Annie -- Hall  |   |   |   |  |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address   |   |  |  |          |
| No --   |  |  | 219-05-9373  |   | Mrs O. Walter Thomas, Pocomoke, Md.   |   |  |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |   |   |  |  |          |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |   |   |   |  |  |          |
| IMMEDIATE CAUSE (a) <u>Arterio sclerosis Heart Deceased</u>   |  |  |  |   |   |   |  |  |          |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |   |   |  |  |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |   |   |   |  |  |          |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |   |   |  |  |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |   |   |  |  |          |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |   |   |  |  |          |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |          |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-13, 1969, to 1-20, 1969, that (I) (we) last saw the deceased alive on 1-20, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |  |  |          |
| 22b. SIGNATURE <u>Wilbur E. Ellis</u>   |  |  |  |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED 1-20-69   |  |          |
| 22d. PHYSICIAN'S NAME (Type) <u>Wilbur E. Ellis</u>   |  |  |  |   | 22e. ADDRESS <u>Medical Center, Salisbury, Md.</u>  |   |  |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)   |  |  |          |
| Burial  |  | 1-22-1969  |  | Downing Methodist   |   | Oak Hall-Accomack-Virginia  |  |  |          |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  |   | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |  |          |
| Robert H. Watson Pocomoke City, Md.   |  |  |  |   | JAN 24 1969   |   | <u>Charles Judge</u>   |  |          |

01744

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL

11-10-1959

ALBANY, N.Y. 12224

TO THE HONORABLE THE SENATE

AND THE HONORABLE THE ASSEMBLY

OF THE STATE OF NEW YORK

IN SENATE

January 13, 1960

REPORT OF THE

COMMISSIONER OF THE DEPARTMENT OF SOCIAL SERVICES

ON THE

ADMINISTRATIVE AND FINANCIAL

OPERATIONS OF THE DEPARTMENT

FOR THE YEAR ENDING DECEMBER 31, 1959

AND THE

RECOMMENDATIONS OF THE COMMISSIONER

FOR THE FISCAL YEAR 1960

AND THE

RECOMMENDATIONS OF THE COMMISSIONER

FOR THE FISCAL YEAR 1960

AND THE

RECOMMENDATIONS OF THE COMMISSIONER

FOR THE FISCAL YEAR 1960

AND THE

RECOMMENDATIONS OF THE COMMISSIONER



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

| 01751  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                          |  |  |  |  |  |  |  |  |  | 01744  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| First Middle Last<br>Salley E. Willey  |  |  |  |  |  |  |  |  |  | Month Day Year<br>January 22 1969  |  |  |  |  |  |  |  |  |  | 9 A M  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>Female   |  |  |  |  |  |  |  |  |  | 4. RACE<br>White   |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH<br>9/18/1908  |  |  |  |  |  |  |  |  |  | 6. AGE (In years lost birthday)<br>67 YRS  |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>MD  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH<br>Wicomico Md.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Deer's Head Hospital |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>HOUSEWORK   |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  |  |  |  |  |  |  |  |  | 13b. COUNTY<br>Wicomico  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN<br>Salisbury   |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER<br>109 Penn Street              |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>IRVING S. OWENS   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>ELIZABETH BRADLEY                                      |  |  |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)<br>No   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>812-16-7173  |  |  |  |  |  |  |  |  |  | 17. INFORMANT Address<br>RONALD WILLEY, SALISBURY, MD. |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u><br>342 X<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Parkinson's Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 days<br>25 yrs                                     |  |  |  |  |  |  |  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)                      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                         |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (A) (this hospital) attended the deceased from <u>August 13, 1951</u> , to <u>January 22, 1969</u> , that (I) (we) last saw the deceased alive on <u>January 22, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                         |  |  |  |  |  |  |  |  |  | 22b. SIGNATURE<br>L. V. Maldve, M. D.  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br>1/22/69  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>L. V. Maldve, M. D.  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS<br>Deer's Head Hospital; Salisbury, Md. 21801   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL  |  |  |  |  |  |  |  |  |  | 23b. DATE<br>1/25/1969   |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>FIREMEN'S  |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>SHARPTOWN, MD.                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NEWNAM FUNERAL HOME, SHARPTOWN, MD.  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>JAN 24 1969   |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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UNITED STATES DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|--|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  |
| 01752  |  | 01745  |  |  |  |  |  |   |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>Margie A. Williams</b>  |  |  |  |  | 2a. DATE OF DEATH Month Day Year<br><b>January 27 1969</b>   |  |  | 2b. HOUR<br><b>10 A M</b>                               |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Negro</b>  |  | 5. DATE OF BIRTH<br><b>March 23, 1897</b>  |  | 6. AGE (In years last birthday)<br><b>71</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Wicomico</b> Md.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Peninsula General</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Domestic</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Wicomico</b>   |  | 13c. CITY OR TOWN<br><b>Salisbury</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>705 Lake St. Salis Md.</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>Frederick Armstrong</b>  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Elizabeth White</b> |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)  |  | 17. INFORMANT Address<br><b>Dorothy Jones 614 Lake St Salis Md.</b>  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cerebral thromboses</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 da</b><br><b>yes</b> |  |  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                     |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-17</b> , 19 <b>69</b> , to <b>1-27</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1-27</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>John T. Bulkeley MD</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |  |  | 22c. DATE SIGNED   |  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>JOHN T. BULKELEY, M.D.</b>  |  |  |  |  | 22e. ADDRESS<br><b>ONE BLUFF RD. SALISBURY, MARYLAND</b>   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/30/ 69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Acres</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Salisbury Wicomico Md.</b>               |  |   |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Clinton F. Stewart Salis Md</b>   |  |  |  |  | 25a. RECEIVED BY REGISTRAR<br><b>FEB 7 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                     |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |   |   |  |   |  |  |
|--|--|---|--|---|---|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |   |  |   |  |  |
| 01753 CERTIFICATE OF DEATH 01746   |  |   |  |   |   |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First (Augusta) Middle Last Williams  |  | 2a. DATE OF DEATH<br>Month Day Year JANUARY 28 1969   |   |  | 2b. HOUR<br>8:10 AM   |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>September 16, 1918  |   | 6. AGE (In years<br>lost birthday)<br>50 YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>WICOMICO Md.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Peninsula General Hospital |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Practical nursing   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>nursing                                      |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland   |  | 13b. COUNTY<br>Wicomico   |  | 13c. CITY OR TOWN<br>Salisbury  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br>R.D. 5, Pemberton Drive                |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Arthur James Leonard   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Mabel Hudson   |  |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>217-16-7895                              |  | 17. INFORMANT (Husband) RD 5 Address Pemberton Dr.<br>Mr. Marvin E. Williams, Salisbury, Maryland   |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Akute failure<br>1991 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, metastatic to liver<br>DUE TO, OR AS A CONSEQUENCE OF (c) 1° source undetermined |  |   |  |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                               |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br>Richard E. Hughes  |  | 22c. PHYSICIAN'S<br>NAME (Type)<br>Dr. Richard E. Hughes  |  |   | 22d. ADDRESS<br>Medical Center, Salisbury, Maryland                             |  | 22e. DATE SIGNED<br>1/28/69   |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>Jan. 30, 1969  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Springhill Memory Gardens   |   | 23d. LOCATION (City or Town) (County) (State)<br>Salisbury, Wicomico, Maryland       |   |  |  |
| 24. FUNERAL DIRECTOR<br>HOLLOWAY & COMPANY, SALISBURY, MARYLAND  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 3 1969  |   | 25b. REGISTRAR'S SIGNATURE   |   |  |  |

11-11-44

REPORT OF LOSS

11-11-44

UNITED STATES

NAVY

REPORT OF LOSS

11-11-44

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UNITED STATES  
NAVY  
REPORT OF LOSS  
11-11-44



CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print)<br>First Middle Last<br>Wanda Lee WILLING  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br>JANUARY 3 1969 |   |  | 2b. HOUR<br>4:24 PM   |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>white  |   | 5. DATE OF BIRTH<br>May 10, 1934  |  | 6. AGE (In years last birthday)<br>34 YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |   | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Wicomico Md.  |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Peninsula General |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Inspector  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Garment  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   |  | 13b. COUNTY<br>Somerset   |   | 13c. CITY OR TOWN<br>Princess Anne  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br>RFD. #3  |  | 14. FATHER'S NAME<br>First Middle Last<br>Herman Bloodsworth                                      |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Annie McGrath  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>214-32-0884                  |   | 17. INFORMANT<br>Address<br>John Willing, RFD. #3 Princess Anne   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>General Sepsis</u><br>5400 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Ruptured Appendiceal Abscess</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Appendicitis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>7 days<br>7 days<br>18 days |  |   |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                      |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/1, 1968, to 1/2, 1969, that (I) (we) last saw the deceased alive on 1/2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br>Osborne Chris Christensen M.D.   |  | DEGREE  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br>1/6/69  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>OSBORNE CHRISTENSEN  |  | 22e. ADDRESS<br>3215 DIVISION STREET<br>SALISBURY, MARYLAND                                       |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>1/5/69   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Beechwood Cemetery  |  | 23d. LOCATION (City or Town) (County)<br>Princess Anne; Somerset;                               |  |
| 24. FUNERAL DIRECTOR<br>Dennis Hanna   |  | ADDRESS<br>Princess Anne, Md.   |   | 25a. REC'D BY REGISTRAR<br>JAN 10 1969  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |

7-7-19

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[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]